Life after suicide: Psychotherapists and practitioners speak about their experiences of working with suicidal clients and the impact it has on them when their client dies

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Submitted by Susan Scupham

Candidate number: M00388379

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Abstract

Life after suicide: Psychotherapists and allied professionals speak about their experiences of working with suicidal clients.

Suicide is a significant problem in Britain. The Office for National Statistics (2016) states that in 2014 that there were 6,122 suicides and considerably more who attempted to end their life. For practitioners working alongside suicidal clients it can have a major effect on them if their client dies.

The first phase of this research project used an online survey which covered a broad range of questions in relation to the impact of working with suicidal clients. The responses were analysed using descriptive statistics and thematic analysis.

In the second phase of the research project, sixteen participants were interviewed using a narrative approach in order to hear at first-hand their experiences of working with suicidal clients. The transcripts were analysed using both narrative and thematic analysis.

The findings highlighted how overwhelmed practitioners felt at the time of their client's death expressing shock, sadness, anger, guilt and helplessness. In addition the findings revealed that years later practitioners were still marked by the experience stating "You don't forget", "Thinking about it produces a feeling of horror" and "It creates anxiety and apprehension when I encounter similar patients".

The findings identified that practitioners faced challenges with decision making, transference and countertransference and risk assessment. They were unprepared for the emotional impact following the suicide of their client and the need for intentional self-care. It was also recognised that practitioners required support at a personal and professional level and that training needed to be fit for purpose.

Analysis from a mixed methods pluralistic perspective would suggest that there is not a single answer to aiding practitioners when their client dies. The recommendation is made that practitioners would be best supported if the issue of client suicide is recognised as a shared responsibility, between employers, professional bodies, training providers,

supervisors and practitioners, and working together to maintain standards of care, support and training. This will aid and prepare practitioners for working with suicidal clients, and should their client die by suicide, practitioners will have a greater degree of support to enable them to negotiate the practical, emotional and professional challenges in the days, months and years which follow.

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Chapter One: Introduction

In this first chapter I will outline the research rationale from a personal and professional perspective, including how my interest in this subject arose. I will then highlight the problem of client suicide, and the impact it has on practitioners. Finally, I will discuss how this study will make a valuable contribution to professional practice.

1.1 Personal Context

I was a pitifully shy and anxious child, who experienced nightmares on a regular basis; it was always my father who came to comfort me. When I was seven years old, my father's job relocated and we moved from London to Essex.

Within a few months of moving, I experienced my first encounter with death. My mother had been in the kitchen cooking dinner, and as I entered the room she told me that my grandmother had died. The news was delivered in a matter of fact way, without any emotion and I was shocked at what I was hearing. I had had no preparation for the news, and no knowledge of my 'Nan' even being ill. I wonder now in retrospect, whether my parents had withheld news of her illness in order to 'protect' me. However I recall going to my bedroom and crying alone, not knowing how to make sense of what had happened.

Thus as a seven year old child I struggled to grasp the meaning of death- my mother told me that my Nan had 'gone to heaven'. I often thought about this statement, wondering what my grandmother might be doing there, questioning who she was with, and what exactly was this place called 'heaven'- where old people went. Would I ever see her again? My mother told me I would see her again when I died and also went to heaven. I recall being afraid of that suggestion, as although I loved my grandmother I was fearful of old people, and the thought of being with so many old people all at once was quite overwhelming.

In the following months my father became increasingly unwell, and was eventually taken to hospital. I remember standing outside my house with my younger sister and a neighbour called Peggy, who told us to wave goodbye to the ambulance as my father was rushed to

hospital. I recall going back into the house and praying to God 'Please make my daddy better- I promise I will never be naughty again if you make him well'.

My father had several strokes and kidney failure, but was expected to make a good recovery. This was a difficult time for my mother, but just as when she had lost her mother, she showed no outward emotion.

One day, whilst at school, a friend who went home for lunch, came back to school and told me that my father had died. Interpreting it as a cruel remark, I dismissed it until I got home, and discovered that she had told the truth.

The confirmed news of my father's death was not given to me by my mother, but by someone who worked with my father, named Carole: she took me to my bedroom, sat down on the bed next to me, and told me my father had been very ill, and that he had died earlier that day. She then cuddled me as I cried, and this cuddle from a stranger was the last I had for many years to follow. There were many unanswered questions in my young mind: How could my father possibly be dead? He had not been old (like my Nan) and I had thought that he was getting better. Why could the doctors not make him better? I thought that was their job to make people well. Perhaps I had been bad and this was a punishment? Why had God not answered my prayer?

On the day of my father's funeral, my sister and I were taken out for the day by a friend of the family. I thought it was exciting having a day off of school, but had no idea why it was happening. When we were dropped back home, the house was full of family and friends eating and drinking. It was here that my paternal grandmother told me that my father had often cried as a child, saying that he did not want to grow old. She went on to say that he had got his wish, and he would never become old. Again the questions swirled through my mind: What did she mean? Why did he not want to grow old? Surely he had wanted to see me grow up and share in all my significant moments? Surely he had not wanted to die? Surely he had never wanted to leave me?

In my adult life, my thoughts about death are that we fear it, just as children fear going into the dark: for adults and children the basic causes of fear are the same since both death and darkness present a mystery. What do they hold? What does the darkness hide? What waits

us in death? We cannot see the familiar scenes and well-loved faces to comfort and reassure us, so it appears to be stepping into the unknown, or into possible non-existence.

Levinas describes this mystery when he writes 'The unknown of death dignifies that the relationship with death cannot take place in the light, that the subject is in relationship with does not come from itself. We could say it is in relationship with mystery' (Levinas, 1989: 40).

Although my father had not taken his own life by suicide, I reasoned that if he had really not wanted to grow old, then his wish had been granted. The implications of my father's fairly sudden death caused me to question why he had died, and resulted in me feeling scarred by a perceived sense of rejection. His death therefore had a profound impact on the person I was to become, the life decisions that I would make, and the research topic that I would choose.

In the years following my father's death, I was desperate to feel loved and made a transition from 'shy girl' to 'naughty girl'. I drank to excess, spending a lot of time with boys, and doing everything that my mother would not have wanted me to do. I wanted to be loved, but went about finding it in all the wrong ways; because I felt so lonely I did not care about the consequences of my behaviour I also made a statement by not attending lessons ,and was eventually excluded from school.

This resulted in me leaving school without any qualifications, and in the years which followed, because I lived a destructive lifestyle, and forming relationships that were not healthy. I knew that I needed to escape, otherwise I would literally not survive. Despite having no qualifications, I commenced a career in retail, which enabled me to start on the ladder as a management trainee. I was a competitive person and worked extremely hard to attain my goals. By the age of nineteen, I worked for the Harrods Group where I managed a department of twelve staff which gave me status; I was also engaged and this this gave me a sense of safety.

As I was making plans for the wedding, and looking forward to a new life, I recall my mother telling me that Peter had died. What did she mean Peter was dead? I stood looking at my mother as she explained how Peter had laid down on the train tracks, and been struck by a

train. I could not take in the information she was telling me, and went into the sitting room to look across the road at Peter's house.

Peter's mother Peggy, had been our childminder whilst my mother worked, so we had often played together. Peter was a year younger than me and although we were not close, I was stunned to hear that he was dead. What could have made him want to kill himself? In the following days, the national press endeavoured to gain interviews. However I returned to my normal self, continuing with my wedding plans, and working very hard. Peter's family never recovered from the traumatic event, and his brother Mark went on to kill himself twenty five years later.

My personal story illustrates how the mystery of death becomes significant to an individual, and how many of us construct our lives in an attempt to avoid the ever present problem that death is always lurking in the shadows. We remain busy working, studying and being part of a family and community, until death tracks us down. We are then starkly reminded that human life is short, and that the certainty of death remains a reality despite our best efforts to hide from it.

Yet for those who end their life by suicide, the great mystery of death is embraced. Perhaps the need to escape the struggles of life feels greater than the unknown entity of death: some may believe in a peaceful afterlife which will free them from their pain, while for others it may be that nonexistence is preferable to continued existence. However those left behind can feel perplexed and wounded when a suicide occurs.

1.2 Professional Context

As my career progressed, I moved from retail management into human resource management. As a Human Resources Manager, I was confronted with people who did not just have work related problems, but difficulties with their everyday life. This led to the decision to train as a counsellor, and I went on to successfully complete a two year humanistic diploma course covering person centred therapy, transactional analysis and Gestalt psychology. It was during this time that I was diagnosed with dyslexia and dyspraxia.

After spending years believing that I was 'stupid', I wanted to catch up on the education I had missed. I was accepted at the University of Surrey to study for a Master of Science (MSc) in Counselling and Psychotherapy as a Means to Health. The course encompassed existential, phenomenological and postmodern perspectives, and I completed a dissertation entitled 'Working with suicidal clients: what are the possible effects on the therapist?' It was a qualitative study, using discourse analysis to examine eight transcripts of interviews with therapists, speaking about their experiences of working with suicidal clients. Six interpretive repertoires were identified, those being power, impotence, identification, distancing, relationship and impact.

Subsequently, over the following years, a greater number of my clients were presenting with bereavement issues; a number of clients had experienced family members taking their life by suicide, and an increasing stream of clients where vocalising suicidal ideation. I noticed that within some counselling settings, if a client mentioned suicidal ideation, a referral to mental health services had to be made, whereas in other settings the client was referred back to their GP. I wondered whether this might hinder clients from speaking of, and exploring their suicidal thoughts. Also within some counselling environments, the inability or unwillingness of the agencies to allow their counsellors to work with suicidal clients, may portray an impression that working with this client group was too dangerous. Perhaps some agencies or services just did not want the responsibility or stigma of client suicide?

Some of my colleagues had also spoken of their concerns about having to refer clients on to other agencies, and how this termination of the therapeutic relationship could not, in their opinion, be a positive action for the client. Others expressed fears of working with clients who had suicidal ideation, as they felt ill-equipped and untrained for the task. These dilemmas stimulated my academic interest; could it be that to work with the pain of a person on the edge of existence is not an easy place to be? Would the suicidal thoughts of another person force us to question the value and meaning not only of life in general, but also of our individual lives?

In my present role as Clinical Service Manager with Talking Therapies- part of Improving Access to Psychological Therapies (IAPT) - I lead a team in excess of a hundred staff, who

deliver psychological support to clients suffering with anxiety and depression. In this role, I have had to support staff whose clients have taken their life by suicide, and to deal with distressed and angry family members whose relatives have died by suicide. I have also had to undertake investigations when such incidents have occurred, and attend Inquests at the request of the Coroner.

One observation from the investigations I have been involved with, is that a surprising number of the suicides were carried out by practitioners who had professional knowledge of mental health, such as psychologists, nurses and paramedics. It would seem that some practitioners knew how to hide their symptoms, so that the gravity of their suicidal ideation would not be discovered. They also appeared to have a more sophisticated knowledge of what was required, in order to ensure that their suicide attempt did not fail. This caused me to focus on how staff within the caring professions can be best supported, in the complex and stressful work which they undertake.

When a person takes their life by suicide, the impact on family, friends and colleagues can be life changing. I recall a client whose teenage son killed himself, and ten years after his death his bedroom was exactly as it had been on the day he died. For my client the bedroom served as a way of preserving the memory of her son, whilst her husband had vowed never to speak of their son. However, how does the suicide of a client affect the practitioners who have been working with the individual? Are practitioners able to carry on 'as normal' following a client suicide? These were all questions which stimulated my academic interest.

1.3 Research Rationale

The purpose of this doctoral study, is firstly to examine the experiences of not just psychotherapists, (as I did in my MSc), but also other practitioners such as nurses, support workers or doctors working with suicidal clients. Secondly, I will explore the impact it had on them, personally and professionally if their client died by suicide.

In considering the effects on the practitioner, I believe I will also gain an insight into what helped them and what hindered them in being able to support the client. The learning from

these findings will enable me to create products which will prepare, train and support practitioners in their work with suicidal clients.

1.4 Research Question

The primary research question is:

- Working with suicidal clients: what are the effects on the practitioner?

In addition to the main research question I will consider the following questions:

- What support do practitioners require when working with suicidal clients?
- What are the training needs of practitioners working with suicidal clients?

1.5 The Problem of Client Suicide and the Impact it has on Practitioners

The Office for National Statistics (2016) states that in 2014 that there were 6,122 suicides in people aged 10 years and over in the United Kingdom (UK), and considerably more who attempted to end their life. When someone ends, or attempts to end their life in this way, it has a significant impact on family and friends. In addition for those individuals receiving psychological support, there can be a major effect on the practitioners who worked alongside them such as psychiatrists, counsellors and social workers. A nurse mentioned to me recently that in his work he was faced with high levels of distress and horrific accounts. The way he dealt with this was to push any unpleasant thoughts and feelings out of his consciousness, and that alcohol at the end of each day helped even further to suppress disturbing thoughts. A counsellor whose client had killed himself, reported that she had become so risk averse that she was considering a change of career because her resulting anxiety level was so problematic.

The subjects of suicide and attempted suicide, continue to receive considerable attention through the media. There is also some government intervention aimed at reducing the rate of deaths by suicide in the UK. The government's paper on preventing suicide in England, produced by the Department of Health (2012), outlined a plan to reduce death by suicide in the UK by 2015. In addition, the Department of Health (2011) in their paper 'No Health Without Mental Health', described how they aimed to improve the mental health of the

nation. They also proposed actively focusing on strategies to alleviate suicide, particularly in the high-risk areas such as middle aged men. Nick Clegg (MP) outlined the Department of Health (2015) policy on 'Zero Target for Suicide in Mental Health Services'.

However, despite government initiatives, suicide rates in England have steadily increased. The 'Five Year Forward View of Mental Health (2016)' states that the rise in suicide is most marked in middle aged men. The report indicates that in men aged 15-49, suicide is the leading cause of death. It recommends NHS England, with support from Public Health England, should identify what steps services should be taken, to ensure that all deaths by suicide across NHS-funded mental health settings are learned from, to prevent repeat incidents. This should build greater insight, through learning from serious incident investigations.

Those in the field of counselling have responded to the escalating suicide rates by producing articles, guidelines and procedures on the subject. However, what do practitioners working with suicidal clients require in order to support them in working effectively with this client group?

The British Association for Counselling and Psychotherapy (BACP), in their Ethical Framework for Good Practice (2016), indicates that when a client shows symptoms related to the possibility of causing serious harm to themselves, this can be particularly challenging for the therapist. Reeves et al (2004) highlight that counsellors are generally poorly prepared through their training experience for working with suicidal clients.

Plakun (2001:269) indicates that in suicide, therapists are likely to feel that … 'someone has betrayed us and murdered our patient, often violently, and the villainous murderer is our patient.' He believes that this has a profound impact on the therapist. Talseth et al, (2000) examined the experiences of therapists in treating patients that talked about committing suicide. The findings suggest that the importance of confronting feelings related to death, in order to help patients manage these feelings.

Within the subject of suicide there are of course, ethical implications which can weigh on the mind of the therapist. Field (1993) writes about the conflicts that arise for health professionals working with suicidal clients. At one level, the client has an autonomous right

to determine their own life, and yet there is a safeguarding obligation on the practitioner, to protect a person believed to be incapable of making a rational decision for themselves.

Hendin et al, (2004), Anderson (2000), Hawton and Simkin (2003), McAdams and Foster (2000), Gulfi et al (2010) and Veilleux (2011) carried out separate studies to investigate the impact of suicide on therapists. In summary their research studies concluded that therapists experienced strong emotional responses including anger, sadness, grief, shock, fear, confusion, shame, guilt and relief. They also highlighted that a significant number of therapists perceived their training to be inadequate. An additional suggestion was made that there is a need for further study of the long-term effects of suicide on practitioners.

Wurst et al (2011), Wurst et al (2013) and Sanders et al (2005) comment that the elapse of time did not seem to indicate a lessening in the reaction to client suicide for some practitioners. Knox et al (2006) observed that a proportion of practitioners were unhappy with the manner in which they were informed of their clients suicide, and were distressed at being invited to share their feelings publicly in team meetings.

Although the aforementioned studies identify some of the challenges faced by practitioners, they also recognise deficiencies in professional training and support. For instance problems were detected such as being poorly prepared during training, where potential therapeutic solutions were not proposed. Although strong emotional responses encountered by practitioners were ascertained, the longer term effects were not explored. Many of the researchers indicated that further research into these areas was necessary in order to bridge the gap.

1.6 Aims and Objectives of Doctoral Research

Referring to client suicide, Coltart wrote:

'It has to be survived; the practice with many other patients has to go on, with the therapist's self-confidence and individual attention to those patients as intact and resourceful as possible'. (Coltart1993:45)

While much is written about suicide in general, far less is specifically related to those professionals working with clients who are struggling to stay alive.

Therefore, the aims of this research study are to consider the following aspects:

- How practitioners are impacted by working with suicidal clients who do not take their life but continue to struggle with living;
- How practitioners are affected by client suicide;
- Practitioners resilience;
- What helps practitioners to support the client;
- What support they needed but did not receive;
- Deficiencies in training;
- Themes arising which are common across the participants accounts.

The objectives will then be:

- To challenge myself at a personal and professional level;
- To design materials to provide continuous professional development (CPD) via workshops and seminars;
- To disseminate learning and knowledge at Health Care, Counselling and Suicide Prevention specific conferences;
- To provide specialist insight into National Health Service (NHS) and IAPT forums;
- To influence NHS policy on support and training for practitioners working with suicidal clients;
- To contribute to the current body of research in this field;
- To publish a book containing the accounts of practitioners' experiences.

As clients continue to die by suicide, the government will continue to strive to reduce and potentially eradicate this form of death in the UK. How will the therapeutic profession respond? As a member of the counselling profession I believe this doctoral study will generate products which will help to both prepare and support those working with suicidal clients.

1.7 Outline of Chapters

Chapter One outlines the personal and professional rationale of the researcher to embark on this doctoral research. It introduces the problem of client suicide and the impact it has

on practitioners. This chapter also establishes the aims, objectives and the structure of the thesis.

Chapter Two reviews the research literature and historical context of suicide in the UK, in order to develop an understanding of the implications for practitioners of working with suicidal clients.

Chapter Three provides the rationale for the development and design of this research study. It discusses the philosophical, epistemological and methodological ideas which informed the decision making in implementing a two phase mixed method pluralist approach.

Chapter Four describes the two phase approach used to carry out this research. The first phase details the survey which used statistical and thematic analysis to analyse data. The second phase illustrates the use of interviews which were analysed using narrative and thematic analysis. The chapter also outlines the ethical, quality and validity considerations of this research study.

Chapter Five presents the findings from phase one of the research study, and summarises the findings from both quantitative and qualitative data.

Chapter Six explores the findings from the narrative analysis carried out at phase two of the research.

Chapter Seven outlines the findings from the thematic analysis undertaken in phase two of the research.

Chapter Eight discusses the key findings from this two phase mixed methods research study in relation to the proposed research questions, and the literature review.

Chapter Nine considers and evaluates the outcomes and products devised from the research findings.

Chapter Ten provides an overall summary of the research study, along with personal reflections of my doctoral journey.

In the next chapter I will review literature relating to this subject.

Chapter Two: Literature Review

This chapter will review the research literature and historical context of suicide, in order to develop an understanding of the implications for practitioners of working with suicidal clients.

2.1 The Literature Search

Three databases were searched (PubMed, PsycINFO and CINAHL) using combinations of the following words: therapist, suicide, psychotherapist, 'therapists affected by suicide', 'suicidal ideation'.

Papers were excluded if they were not full text or if found to be a duplicate. Many papers were rejected because their emphasis was on the assessment, risk management and treatment of suicidal clients. Others were excluded due to their content being on specific client issues, such as depression or personality disorders and suicide. Some papers were initially included, but on further investigation found to be less focused on the impact and effect of client suicide on practitioners. These papers included therapists who had mental health problems, therapist suicide, family and friends bereaved by suicide, resources for the bereaved and legal issues.

A record of all papers scrutinised was kept for review in an Excel document, outlining relevant details, such as whether the article was a hard or electronic copy, colour coded to note categories, and highlighted if referenced in this doctoral study. Papers which I was unable to gain from online databases were sourced by the Berkshire Healthcare NHS Foundation Trust (BHFT) library from the British Library.

2.2 Overview

Worldwide in excess of 800 000 people a year die by suicide and many more individuals attempt suicide. The devastating consequences of people attempting suicide or dying by suicide leaves a significant impact on families, friends and communities. Clearly, for families and friends, the aftermath of seeing loved ones suffering with suicidal ideation, or attempting to take their own life, or dying by suicide is a profoundly distressing experience.

Although it is not my intention to detract in any way from the loss experienced by family and friends, within our communities, psychotherapists, doctors and other mental health practitioners are also affected. Firestone (1997) believes that the practitioner may suffer many of the same psychological reverberations as survivors who are family members.

The subject of suicide is a broad area and much has been written in relation to the problem within society, and in particular its prevention. As mentioned in chapter one there have been government initiatives to try to reduce suicide in the UK, and professional bodies and organisations have responded by producing guidelines on prevention and best practice.

Whilst much has been written in a general sense, Parker (2014) highlights the gap in literature in the area of suicide bereavement, and literature related to the impact of working with suicidal clients on the practitioner, is also poorly addressed. Grad (1996) commented on the ratio of articles dealing with relatives' bereavement after suicide versus articles about practitioners' reactions stating it to be approximately25:1 : twenty years later, I do not think this ratio has changed significantly.

Prior to exploring what the literature has to contribute as to how practitioners are impacted by client suicide, I am going to outline the possible reasons why people choose to take their own life and to trace the historical context.

Karl Menninger is referred to as the grandfather of American suicidology. Menninger (1938) suggests three possible rationales as to why people choose to take their own life. Firstly, the person has a strong desire to escape from the life they are living. Secondly, the individual may have a need to punish themselves, and lastly, the act of suicide may be aimed at causing pain to others.

Edwin Shneidman founded the American Association of Suicidology in the late 1960's. Shneidman (1996) defines suicide in the following way;

> "In almost every case suicide is caused by pain, a certain kind of pain – psychological pain, which I call psychache. Furthermore, this psychache stems from thwarted or distorted psychological needs. In other words, suicide is clearly a drama in the mind" (Shneidman, 1996: 4).

Lester (2011) suggests motives for suicidal behaviour are wider than this, and outlines his view that reasons for suicidal behaviour need to be considered in the light of a cultural context. Lester emphasises that different cultural meanings may be present within the subgroups of a culture, such as men and women, young and old, as well as different social classes. Lester also indicates that the cultural meaning of suicide may change over time, along with variations in the different types of suicidal acts.

The World Health Organisation (2014) states that:

> "No single factor is sufficient to explain why a person died by suicide: suicidal behaviour is a complex phenomenon that is influenced by several interacting factors – personal, social, psychological, cultural, biological and environmental".(WHO 2014)

The Samaritans (2015) define suicide as 'intentional self-harm and events of undetermined intent'. Attempted suicide is also complex to interpret, and interrelated to suicide itself. Kerkhof (2000: 50) defines attempted suicide as 'an umbrella term that covers a number of different behaviours'. Although the outcome of their acts of harm result in being non-fatal, there are many varied behaviours by which people inflict acute harm upon themselves. He goes on to indicate that some attempts are aimed at dying, others are aimed at gaining help, and others are to some extent aimed at both. It would seem some people's attempts are well-prepared, while others are an impulsive act. In some cases, people who perform potentially lethal self-destructive behaviour, do not in fact have any wish to die, but impulsively act out of a wish to change their circumstances. Conversely, others who present with minor self-injury may have had every intention of wishing to die, but did not have sufficient knowledge for the attempt to result in death.

Rudestam, (1986) states that:

"Practitioners who experience client suicide know the agonising soul searching which follows". (Rudestam, 1986: 84)

A considerable amount of the literature relating to working with suicidal clients, indicates that practitioners report high levels of stress and anxiety. (Farber, 1983, Chemtob et al, 1989, Jobes and Berman, 1993, Oordit et al, 2005, Hendin et al, 2006 and Ellis 2012). Firestone (1997), Birtchnell (1983), Deutsch (1984) and Hendin (1981) all suggest that when a client expresses a suicidal intention, this causes therapists to experience more stress than any other behaviour or communication.

The stress and anxiety generated from working with suicidal clients, may result from the unique role that mental health practitioners have for the clients' therapeutic care. Gitlin (2007) and Jobes et al (2008) make comparisons between the clinical fields of oncology, cardiology and psychology. Patient deaths in the area of oncology and cardiology are routinely attributed by practitioners and survivors alike to factors external to the practitioner- perhaps the limitations of the technique, or the severity of the illness. However, Gitlin refers to:

> "…the deep assumption that many of us adopt that each of us is the primary instrument of therapy" (Gitlin, 2007: 687).

Similarly, Joiner states the difference with the area of psychology is that:

> "…the practitioner is in part the technique. The limits of technique, therefore, take on an intimate and personal quality. It is tragic that the practitioner cannot prevent all deaths by suicide" (Joiner, 2008: 413).

I believe that the suggestions made by Gitlin (2007) and Joiner (2008) are a fundamental reason why practitioners are impacted so profoundly by client suicide.

I will now take a moment to consider the development of thinking in relation to suicide through history in order to reveal a perspective on the role of responsibility for suicidal acts.

2.3 Historical Context

The current focus on suicide is by no means new; according to (Bille-Brahe, 2000) both Socrates and Plato voiced their opinions. He indicates that Socrates argued:

"that a life without opportunities for critical thinking was not worth living" and "that this blessing on death came to act as an inspiration for many suicides in the years to come". (Bille-Brahe, 2000: 199)

Plato apparently hinted that if:

"…life became unbearable, suicide was both a sensible and justifiable act". (Bille-Brahe, 2000: 199)

In ancient Greece, convicted criminals were allowed to take their own lives. However, the Roman attitude towards suicide hardened towards the end of the empire due to the high incidence of suicide among slaves who denuded their masters of valuable property.

Bille-Brahe (2000) comments on the condemnation of self-killing that was apparent in Judaism, with the sacredness of life being of great importance, and the taking of one's own life as a serious offence. Bille-Brahe goes on to emphasise how in the Old and New Testaments of the bible, theologians are not in complete agreement as to the act of suicide. Some would seem to say that when a person is faced with defeat or dishonour the biblical attitude to suicide seems to be that it is acceptable. In the New Testament one can read the account of Judas the disciple who betrayed Jesus and then took his own life. From the eleventh century the Catholic Church considered this to be a more serious sin than that of actually betraying Jesus.

O'Connor and Sheehy (2000) and De Leo et al (2006) refer to the development of early Christian teaching over time, to reinforce that taking one's own life was ultimately a rejection against God's will: this resulted in suicide becoming an unforgivable sin. The Church legislated against suicide and by 533AD those who took their own life were not permitted to have funeral rites, and by 693AD those who attempted suicide could be excommunicated.

During the Middle Ages, the Church took action against the families of those who committed suicide by confiscating their property and tarnishing them with disgrace. The souls of the dead were thought to be condemned to eternal suffering. With suicide being viewed as a criminal act, those who attempted suicide were placed on trial.

The concept of suicide being a mortal sin continued on through the centuries, and Bille-Brahe, (2000) writes of a further development of this attitude into the care of one's neighbour. If suicide was wrong it was essential to prevent it occurring, and this introduced the concept of guilt related to suicide:

> "Not the guilt of the sinner, i.e. the person who committed suicide, but the feeling of guilt in those who had not been able to prevent, or perhaps even felt responsible for the sin (the suicide). Attitudes towards suicide were heavily tainted by both the concept of sin and the notion of guilt, together bringing about the taboo that for years has dominated this field." (Bille-Brahe, 2000: 200)

Although this attitude towards suicide dates back to the Middle Ages, I would suggest that a significant number of practitioners continue to carry a sense of needing to prevent suicide in their clients, at all costs.

Up until the late 19th century, family members of the deceased were held responsible following the suicide of their loved one, often resulting in punishment, persecution, stigma and loss of status. It was not until 1961 that the Suicide Act decriminalised suicide in the UK. However, there are still countries today where the act of suicide remains a crime.

2.4 The Impact of Client Suicidal Behaviour on the Practitioner

Client suicidal ideation, attempts and suicide can impact practitioners at both a personal and professional level. Literature would suggest that the impact is dependent on many factors.

Litman (1965) and Grad (1996) suggest that the explanation the practitioner is given for the suicide, the life stage of the practitioner, along with their theoretical, philosophical, and

clinical background can all play a part. Ellis and Patel (2012) include factors such as whether the person was a present or former client, or if the treatment was individual or group. They go on to outline that while the impact on practitioners is extremely stressful, some clinicians are able to reflect on their own personal and professional development, seeing the event as an opportunity to learn from rather than to be broken. Plakun and Tillman (2005) reinforce the notion of potential learning and growth, stating that it can provide an opportunity to develop a greater sense of professional identity.

Grad (1996) describes the reactions of health practitioners to client suicide as stimulating a sense of failure and guilt. Similarly, to Joiner (2008) as mentioned earlier, Grad purports that practitioner bereavement following the death of a client from health related issues such as cancer, is very different to death by suicide. Grad reports that practitioners experience greater levels of anxiety, guilt, and feelings of stigma, along with negative rumination and self-questioning, in their efforts to try and understand the meaning of the suicide. Grad outlines how practitioners can experience disturbing mental images, nightmares and flashbacks due to the traumatic nature of client suicide. Grad states few events in medical practice result in such a sense of failure and guilt as the suicide of a client.

Sudak et al, (2008) report that although mental illness has become less stigmatised over the years, suicide continues to be an area which remains branded. Oulanova (2014) suggests suicide can leave the survivor feeling traumatised, conflicted due to stigma, depressed and experiencing complicated grief. Pritchard (1995) indicates that unlike death from illness, which one did not choose, it is the apparently deliberate nature of the act of suicide that is so difficult to accept or understand. He goes on to say that it cannot fail to hurt the practitioner involved. It would seem that the unique way in which a client takes their life during the therapeutic relationship could also be traumatic for the practitioner.

Horn (1994) reviewed literature to examine practitioners' cognitive, behavioural and emotional responses to suicide. Cognitive responses included therapists having intrusive thoughts about the suicide, and concerns about legal issues. Behavioural responses were identified as being both positive and negative. Positive responses were recognised as the

ability to facilitate the working through of grief, whereas negative responses could obstruct the process. Factors such as a therapist's life experiences and schemas were also outlined as impacting on the recovery of the therapist.

Richards (2000) carried out a study of psychodynamic and psychoanalytic psychotherapists. 100 psychotherapists were invited to complete a questionnaire on their experience of working with suicidal patients. 58 returned the questionnaires of which 6 had experienced patient suicides, and 29 had worked with patients who had attempted suicide. Many of the therapists conveyed a sense of being attacked by the patient during therapy. Richards endorsed the need for recognition and understanding of countertransference responses, along with therapists acknowledging when there was a shifting of boundaries.

Mishane (2004) explored the difficulties that practitioners experienced in making a referral for emergency hospitalisation for their suicidal patients. A case example was examined with particular reference to the practitioner's countertransference responses. Mishane suggests that self-injurious behaviours can provoke profound anxiety and fear in practitioners, and recommends that more understanding is required to grasp the countertransference responses evoked in practitioners.

I believe that it is highly likely that the profound turmoil experienced by suicidal clients is going to be conveyed via transference and countertransference responses. It would seem of significant importance for practitioners to have an understanding of this powerful process, to monitor their responses and discuss in supervision the impact of such communication. I would go as far as to state that if this is not analysed with a supervisor or mature colleague, the practitioner could be left feeling emotionally bruised or wanting to withdraw from the client.

Hendin et al (2000) reported that grief was the most common response to the suicide of a client followed by guilt. Some participants indicated that their guilt was also expressed in their dreams or fantasies. Practitioners expressed a fear of being blamed, with some being concerned about being sued. In addition, practitioners experienced feelings of anger and betrayal in relation to the rejection they felt from the client. Their findings highlighted that

experienced practitioners had thought their professional experience would have protected them from fear and doubt, and reported being disturbed when this was not the case.

Hendin et al (2004) invited 34 therapists to complete a semi- structured questionnaire followed by attending an all day workshop. At the workshop the therapists presented and discussed detailed accounts of their experience of working with suicidal clients. The results showed severe distress in 13 of the 34 therapists, and highlighted four specific factors, namely the therapist's failure to hospitalise their suicidal patient, concerns around a treatment decision, negative reactions communicated by the therapists' institution and therapists' fears of a lawsuit.

Hendin et al (2006) continued in a similar vein when they examined the accounts of 36 therapists who took part in initial semi- structured psychological questionnaires and written case narratives. The therapists were invited to present their cases at a workshop to ascertain the problems they encountered whilst treating their patients. Six critical problems were identified in the cases; lack of communication between therapists, permitting patients or their relatives to control therapy, avoidance of issues, ineffective or coercive actions resulting from therapist anxiety, not recognising the meanings of patients' communications, and finally untreated or undertreated symptoms.

I am intrigued by the combination of individual reflection via questionnaires and group interaction used by Hendin and his colleagues. I imagine that having the opportunity to process one's experiences of suicide in a workshop setting could normalise the event and help the practitioners to feel less alone. However, practitioners who felt particularly vulnerable or self-critical of their work may not be willing to undergo such an exposing forum.

Veilleux (2011) examined her personal experience of a patient suicide stating she initially felt disbelief and shock. During the subsequent weeks Veilleux revealed thoughts that perhaps her patient's death might be a practical joke, and that the patient might still be alive. Veilleux was grateful for the support her supervisor demonstrated in the following weeks and how she helped her navigate difficult emotions such as anger. Veilleux experienced many unanswered questions around the death of her patient. There was also a

sense of relief at not having to struggle with the patient any longer, followed by a sense of guilt, and questioning of whether she was a bad therapist to think in this way. Veilleux (2011) concludes by stating that her patient's death had since prepared her to deal with suicidal clients, and increased her academic interest in death and bereavement issues. Most importantly she acknowledged learning about herself, including how to begin to accept the lack of knowledge associated with unexpected death, and a desire to behave as her supervisor did with a non-judgemental acceptance.

Spiegelman and Werth (2005) highlight that while completed suicide is significant for practitioners to go through, those who experience clients who have non-fatal attempts should not be ignored, and should also be supported. Webb (2011) provides a case study of her work with a patient who over the course of two years had suicidal ideation, and carried out acts of self-harm. Webb reflects on her therapeutic work with the patient and the strategies of self-care she applied during her work. Webb recognised the intensity of the therapeutic relationship, and reflected on the countertransference she experienced. Webb made reference to the exhaustion she experienced due to the nature of the work, and lists a number of self-care strategies. These include support and connection with colleagues, having activities which were non-work related, exercise, good sleep, eating well, taking holidays, knowing her own limits, having a diverse caseload, spiritual discipline and personal therapy.

Carter (1971) writes of the stages a practitioner goes through following client suicide. In the initial stage he includes (similarly to Grad, 1996), the need for the practitioner to have factual information such as time, place and method. He suggests that this information is valuable because initially there may be a tendency to deny or disbelieve that the client is dead. This denial and disbelief (as expressed by Veilleux, 2011), can be an expression of the practitioner's shock and desire for the situation not to be real. Sacks et al (1987) refer to the practitioner moving onto a phase of depressive rumination, in a search to ascertain the 'fatal mistake' they made in the sessions prior to the suicide. This can be accompanied by fantasy and introspective rumination, leading to the person feeling overwhelmed and weakened in their ability to cope. Valente (2003: 20) writes of the…:

"…agonizing questions which emerge from a deeper struggle with a sense of power or omnipotence. Struggling with these painful issues alone can often be counterproductive" (Valente (2003: 20)

Carter (1971) suggests that being given clear information provides the practitioner with a shift of attention away from self to the facts. Whilst there is a place for personal refection of the work carried out, it is also vital that the practitioner is armed with the facts of what occurred, and an understanding of the process that will be followed with regard to any organisational investigation.

It is clear from the literature reviewed above that the suicidal actions of clients can profoundly interrupt the practitioner's thinking, emotions and behaviour.

2.4.1 Gender and the Profession of the Practitioner

Grad (1996) and (1997) raises the issue of gender reactions to client suicide. Grad's findings showed that female professionals more often than their male colleagues, expressed a sense of shame, a questioning of their professional ability, and were less likely to carry on as normal following their client's suicide. Grad's research also compared the reactions of psychiatrists and psychologists with other practitioners, such as GPs. Grad's findings showed few significant differences between professions. However, Grad did find that psychiatrists and psychologists spoke to their supervisor more frequently, but reported struggling more than GP's in showing their feelings to their colleagues.

Hendin et al (2004) found that female therapists were more likely to show higher levels of distress than their male colleagues. Darden and Rutter (2011) carried out a qualitative study to explore psychologists' experiences of grief following client suicide. One of their findings was around gender discrepancy, with male psychologists stating that client suicide did not affect them personally. Darden and Rutter found a number of participants reluctant to disclose any sense of a personal impact. Darden and Rutter (2011: 336) posed the questions "does the absence of emotional reaction to the suicide help them to rebound or depersonalise the experience? Were they compartmentalising their emotional response to

deal with death, thus being able to more immediately return to serving their current clients?"

Chemtob et al (1989) followed up data from previous national surveys to compare the frequency and impact of patient suicide amongst psychologists and psychiatrists. 624 questionnaires were sent out and 431 were returned. 167 psychiatrists (62%) and 264 psychologists (28%) experienced patient suicide. Both groups reported experiencing significant disruption in their professional and personal lives following patient suicide. Findings from the research outlined the need for practitioners to have training on how to deal with sudden death. Chemtob et al (1989) also identified that practitioners who had received appropriate training and experience of patient suicide, were less likely to encounter death- related anxiety in their future work.

A study carried out by Rothes et al (2014) examined self-report questionnaires completed by 196 health professionals. Their findings exposed four areas of difficulties which practitioners experienced in their clinical work. The areas were technical, emotional, communication and approaching families/logistical difficulties. Rothes et al (2014) identified that those professionals who had received training in the area of suicide, and had experienced a higher number of patient suicide attempts, appeared to experience lower levels of difficulty, with GPs reporting more difficulties than psychologists and psychiatrists. There was a consensual perception of the need for health professionals to receive appropriate training.

2.4.2 Setting in Which the Practitioner Works

Litman (1965), whilst in the role of Chief Psychiatrist at the Suicide Prevention Centre, and Professor of Psychiatry at the University of Southern California, writes about his experiences of working alongside multiple psychotherapists, although he does not describe any particular research studies or methodology. Despite his credentials, the paper is reflective rather than scientific. Litman highlights that when a suicide occurs in an institution such as a hospital or clinic, the death is more easily accepted by the practitioner due to the mutual support and shared responsibility of the team. However, a study carried out by Horn (1994) reported that practitioners working in an outpatient setting experienced loneliness and

isolation, whereas those based in an inpatient setting felt they were 'in a fish bowl'. These findings demonstrated that both groups of practitioners recognised negative implications to their clinical setting. Farberow (2005) and Valente (1994) raised concerns about psychotherapists in private practice who are not having daily access to support, as do those in multidisciplinary teams. They both recommended that those in private practice plan a collegial support system for when a suicide occurs. Without support, Valente (1994) suggests issues related to grief can lead to increased questioning and self-recrimination. Farberow (2005) adds that this is a time when the support of family and close friends is necessary for the practitioner.

Fox and Cooper (1998) carried out a literature search on burnout and vicarious trauma, and then go on to outline two case vignettes. They highlight concerns around practitioners in private practice who work with suicidal clients. They describe four areas which can lead to burnout from a negative cycle of responses, including emotional exhaustion resulting from the intensity of the work, perceived inability to help the suicidal client, disappointment due to lack of progress, and isolation from social support. They go on to address how practitioners' exposure to their clients' graphic and painful accounts can lead to vicarious trauma. Fox and Cooper (1998: 155) suggest practitioners in private practice set up networks for professional development and support which "will help quality assurance, ultimately making private practice more accountable practice".

Sanders et al (2005) in their study on the impact of suicidal clients on social workers reported that some practitioners felt their experience of client suicide was intensified due to the reaction of their colleagues. In some instances the practitioners were blamed for the client deaths.

Christianson and Everall (2008) in their study of school counsellors, raise concerns about the impact of working within a stressful setting such as a school, on the counsellors' mental and physical health. Similarly to Fox and Cooper (1998) Christianson and Everall (2008) report that practitioners who feel overloaded experience role ambiguity. Lack of supervision and their own inexperience can make them susceptible to burnout.

The literature seems to suggest that irrespective of the setting in which the practitioner is working when a suicide takes place, there is the potential for it to be challenging. If the practitioner is working in private practice it may be of value to have a network of collegues or peer group in which support can be found. Managers and supervisors within organisations need to take responsibility for their teams to ensure that when a suicide occurs, those working with the client obtain the appropriate support.

2.4.3 Career Stage of the Practitioner

Cotton et al (1983) write of their experiences of suicide in an inpatient unit, and comment on the most severe reactions occurring among young mental health workers who had no professional background and limited training. They suggest that those supporting such individuals need to be mindful that for some younger staff members, the suicide may be their first experience of death. Whilst aspects of the interviews provided interesting material, the authors did not provide any details as to how if at all, the data was analysed.

Lynch (1987) examined issues faced by trainees working in outpatient psychotherapy. Lynch states that due to the dyadic relationship, trainees are more likely to face the 'full brunt' of the patients' transferences. The impact on the trainee is that when the patient goes into suicidal crisis the trainee can find they feel cold, useless and worthless. Similarly to Cotton et al (1983) Lynch (1987) does not supply any explanation of method or process; it is also unclear whether the vignettes are hypothetical or real, and the review of literature is minimal.

Chemtob et al (1988) carried out a survey of 254 psychiatrists of whom 51% had experienced client suicide. One of their findings highlighted that trainees expressed feeling ill-equipped to work with suicidal clients and were significantly impacted by the event. Of those surveyed who had experienced client suicide, 57% reported having post trauma symptoms which Chemtob et al (1988) found to be comparable to those found in clinical groups.

Kleespies et al (1990) surveyed a cohort of 54 psychology interns. The results of their study indicated that 1 in 6 interns had experienced patient suicide at some time during their training. A group who experienced patient suicide, and a group who experienced a patient

attempting suicide, both reported high levels of stress on the Impact of Events Scale. Trainees who experienced patient suicide reported higher rates of stress than that of their qualified colleagues. Kleespies et al (1990) made recommendations for training provision to include immediate supportive responses, to prevent traumatisation and to minimise isolation. The suggestion was also made to provide a safe forum for trainees to express their feelings, and to learn from their challenging experiences. Limitations identified in this study are that the sample was small, and it was taken from one cohort, lacking a comparison group.

However, Kleespies et al (1993) carried out a further study on the impact of patient suicidal behaviour on psychology interns using a larger sample of 292 participants. On this occasion their results identified that 1 in 9 trainees had experienced a patient die of suicide, and 1 in 4 had had a patient make a suicide attempt. Trainees who had a patient die of suicide had stronger feelings of shock, disbelief, failure, sadness, self-blame, guilt, shame and depression. Recommendations were made to develop further support for trainees, to help them prepare and manage the challenges of working with suicidal patients. Also, rather than using participants from one cohort as in their previous study, they used interns from different programmes providing a comparison group. In addition to being scientifically robust the authors examine the impact of suicide, suicide attempts and suicidal ideation on the practitioner delivering a detailed overview.

Knox et al (2006) examined 13 doctoral students who had experienced client suicide. Whilst this sample is small, Knox and colleagues wanted to veer away from research based around survey data. They sought to portray the participant's full experience of client suicide, allowing them the opportunity to make suggestions with regard to personal and professional needs. The students reported that they had received minimal preparation from their training to work with suicidal clients. A small number of the students expressed their unhappiness with the manner in which they were informed of the suicide of their client- for example being told in between sessions. The students also disclosed being invited to share their feelings publicly at team meetings. The findings of this study identified that it was the support from colleagues and supervisors which helped the students to cope with the death of their clients most effectively. Knox et al (2006) made recommendations for training to

include not only assessment and treatment of suicidal clients, but also how to process and work through actual client suicide, along with protocols within supervisor training to support trainees. Limitations of this study are that participants were providing retrospective information so their memory of actual details may not be accurate.

Scocco (2008) compares the emotional responses of 10 patients who made attempts to take their life with the reaction of the psychiatrists who were treating them at the time. Patients and psychiatrists were given a questionnaire one week following the suicide attempt. The questionnaire asked the psychiatrists 'what were your feelings when you found out about your patient's attempted suicide?' They were then asked 'Describe your relationship with the patient?' The findings from this study highlighted that the trainee psychiatrists were more able to comment on their feelings and expressed a greater number of emotions. The conclusion drawn was that this may be due to having less experience than their qualified colleagues, and also having more enthusiasm at the start of their career. The more experienced practitioners appeared to play down their feelings, and even denied the presence of emotions. Scocco comments on this possibly being due to self-preservation or professional pride.

Gulfi et al (2010) contacted 559 institutions in order to identify practitioners who had experienced patient suicide. 400 institutions completed a survey and 104 institutions agreed to take part in the research. The final study sample was made up of 275 practitioners. Practitioners were asked to complete a questionnaire and a 9 item Long-Term Emotional Impact Scale. The findings showed that young practitioners seemed to make greater changes to their working practices than their more experienced colleagues, following a suicide. Gulfi et al (2010) suggest this is due to being less prepared to work with patient suicide. Social Workers reported a greater sense of professional repercussions, and this was thought to be as a result of having received less specialised training in working with suicidal patients. Those practitioners whose patients had made multiple previous attempts, or who had previously experienced patient suicide, made fewer changes to their work. This was put down to a greater sense of disillusionment or an increased awareness of professional limitations. While Gulfi et al (2010) proposed the need for training programmes to sufficiently equip practitioners they also suggested that more experienced professionals

who seem less affected by completed suicide, should also receive support in order to prevent them from entering into a state of denial, or from avoidant behaviours which could lower their sensitivity, and possibly inhibit their ability to accurately recognise suicidal tendencies.

McAdams and Foster (1999) carried out a review of literature and from their findings highlight that students can think negatively about their inability to prevent client suicide, leading to a sense of failure, along with serious and often disabling professional self-doubt. However, they add that following client suicide practitioners can view the experience as an opportunity for professional development if they have been sufficiently prepared through their training provider for such events.

Yousaf et al (2002) sent questionnaires to a group of psychiatric trainees at a London hospital. Out of the 89 trainees, 53 responded and 23 reported having experienced client suicide. The trainees stated they experienced significant stress in the aftermath of client suicide, with half of the trainees also expressing that it had been a useful learning experience. The trainees did not consider didactic training to be of benefit, but preferred a more interactive method where modelling techniques could be available.

Much of the literature seems to be focused on the trainee, intern or student practitioner all starting out in their career. Perhaps there is an expectation that at the beginning of our career we lack experience, and so when a significant event such as suicide arises it will pose a greater challenge to the practitioner. Or perhaps the trainees were the keen practitioners who responded to the invitation to reflect on their experiences of suicide?

2.4.4 Time Period Since Suicide

In the study carried out by Hendin et al (2004) a- mentioned previously- they had sufficient concerns about the ongoing impact on participants who had been subject to client suicide, to recommend further study into the long term effects on professional practice.

Sanders et al (2005) carried out a qualitative research study on social workers' experiences of client suicide. Similarly, to Knox et al (2006), Sanders et al wanted to gain in -depth information from participants, rather than utilising a quantitative approach. Questionnaires

containing both open and closed questions were sent to 1000 social workers; 515 were returned of which 145 reported experiencing client suicide. The study's methodology was detailed and clearly laid out, and three researchers independently analysed the data using a thematic approach. The results indicated a range of psychological and emotional reactions occurring following client suicide, which continued through the months and years which followed. Sanders reported that the elapse of time did not seem to indicate a decrease in emotion with regard to the suicide.

Wurst et al (2011) sent a 63 item questionnaire to 185 psychiatric clinics in Germany. The emotional reactions of therapists were measured immediately after a patient suicide, then 2 weeks later and finally 6 months later. The findings highlighted that 3 out of 10 practitioners who experienced a patient suicide suffered from severe distress. Conclusions were drawn from the data to suggest that by identifying those professionals who were severely distressed, more focused support could be offered.

Wurst et al (2013) carried out a second study and contacted 201 psychiatric hospitals in Germany resulting in 226 practitioners from 93 hospitals responding. 39.6% of all practitioners reported being severely impacted by the death of their patient. Wurst suggested similarly to their previous study that if practitioners who experienced severe distress could be identified, earlier support could be put in place. The consequence of this would mean that practitioners could continue to provide quality treatment to other patients. The findings of the 2013 study varied very little from the earlier study in 2011, other than surveying a larger number of practitioners. Despite the repeated study recognising that support of practitioners was key, there were scarcely any suggestions as to the form of that support.

2.4.5 Preparation and Support for Practitioners

Bongar (1992) reviews literature on practitioner competency to work with suicidal clients, and highlights that the practitioner needs to attend not only to practicalities, but also to their own emotional needs. Bongar (1992) goes on to suggest that it is both normal and difficult to work through feelings about suicide attempts and completed suicide, and that when the client completes suicide, the practitioner is left a suicide survivor. Grad (1996)

suggests bereavement support for practitioners needs to be individualised to each therapist, and be at a professional and or personal level, depending on the person's needs.

McKay and Tighe (2013) write about the experience of survivors of suicide, highlighting the loneliness and misplacement of shame that may not be present in deaths due to ill health. One of the unique aspects of bereavement following suicide is the need to ask "why" someone took their own life, and that this is a search which may not yield comprehensive answers. This therefore, might be a time when the practitioner requires personal therapy. Riley (1999) writes that the therapist can have a multiplicity of reactions, many related to personal loss and fear of professional incompetence, and she concludes that this is a time when the therapist needs therapy. This view point is also endorsed by McAdams and Foster (2002).

Norcross (2000: 710) states that psychotherapy is often "gruelling and demanding" and "can take a negative toll" on the practitioner. Norcross points to literature which suggests that practitioners can experience depression, anxiety, emotional exhaustion and disrupted relationships due to the nature of their work. Challenging client material, confidentiality and isolation can all lead to practitioners not being mindful of the personal impact. Norcross indicates the importance of personal therapy for practitioners, and the misconception that some would regard support of this kind as a failure. Farberow (2005) also indicates the value of practitioners seeking personal therapy in order to examine their own emotional responses to the client suicide.

Bongar (1992) suggests the importance of practitioners evaluating their own abilities to work with suicidal clients, and have an awareness of their emotional tolerance when working with this client group. Hendin et al (2004) found that most practitioners were not prepared for the intense emotional responses they experienced following the suicide of their patients. It might be that honest conversations need to occur in practitioners' initial training, as well as during their ongoing management and clinical supervision.

Michel (1997) focused on the personal accounts of practitioners, and suggested that institutions have the responsibility to help individuals to deal with the impact of client suicide. However, he mentions there could be no simple protocol for postvention, and that

each team or institution would have to formulate their own plan. Michel also draws attention to problems within team culture which caused difficulty for practitioners making personal disclosures to colleagues, and concerns around the issue of confidentiality. Michel highlights that awareness is required among health professionals, particularly senior staff in institutions that have the power to influence the culture in their settings, when a suicide occurs. The role of the team, senior staff and supervisors is also considered, stressing the need for provision of counselling where necessary, and specific training on working with suicidal patients to be included in training programmes.

Plakun and Tillman (2005) raised the issue that some practitioners, whilst wanting support from their colleagues had concerns about being judged by them. In addition, they indicated that some practitioners feared the reassurance from colleagues was coming from their peers' anxiety and their need to sooth a difficult situation.

McAdams and Foster (2002) followed up participants from their previous study (2000), to assess the coping resources of counsellors following client suicide. Their main finding was that the support of family and friends provided the greatest support. Although support from colleagues was highly rated, there seemed to be a degree of caution from counsellors, due to "feelings of failure and professional inferiority in the presence of other professionals" (McAdams and Foster, 2002: 235). Richards (2000) also reinforces the value of working in cooperation with other professionals.

Reeves and Nelson (2006) recommend organisational policy and guidance to include practitioner support, such as time out away from clinical work, being able to attend the client's funeral, individual or group time to process the suicide, named contact for support, along with additional supervision and personal therapy. They advocated a 'good network of support externally and internally' and perceived a danger that practitioners "will act out their anxiety within the therapeutic relationship and move into defensive practice" (Reeves and Nelson, 2006: 17).

Lynch (1987), Horn (1994), Richards (2000) and Fang et al (2007) indicate the role of the clinical supervisor as being essential. Supervisors require sufficient awareness of suicide, and the ability to steer the practitioner in the right direction following client suicide. Sacks

et al (1987) mention the importance of reviewing the case in supervision to explore if 'we missed anything'. They state that this helps the supervisee, particularly if a trainee, to deal with guilt and genuinely consider whether errors were made together. Knox et al (2006) also suggest protocols within supervisor training, to ensure that new colleagues- particularly trainees- are steered through the challenge of client suicide.

Whilst supervision is mandatory in a number of professions, and hopefully valued- particularly at times of crisis for others- the quality of supervision they receive may be poor, or they may only have access to management supervision. Ellis (1986) relates that practitioners often feel impotent when dealing with suicidal clients, and some supervisors have little advice to offer, other than management techniques. This raises concern about some practitioners feeling unsupported and vulnerable in their clinical work.

Takahashi (1997) considers the responses of psychiatrists' to patient suicide and makes recommendations on what support should be available. He suggests postvention to reduce the aftermath of the traumatic event and the use of supervision. He outlines a number of points which he believes the supervisor could offer to support the clinician. In addition he recommends that psychiatrists who have experienced patient suicide should have psychological support, and have the opportunity to learn from such events in order to plan supportive treatment for their patients.

Overholser (2008) raises concerns about professionals who may be carrying out research, publishing clinical guidelines or providing clinical supervision without having up to date experience of working with suicidal clients. These professionals may have a mind-set of confidence, but Overholster warns of the possible gap in their competence to instruct others. He goes further by suggesting that if they have not had their own clinical caseload in the past two years their skills will be deficient:

"It seems that many who are considered experts are teaching the next generation of clinicians and writing the authoritative texts in the field even though they have failed to maintain their own competence in the clinical skills required for effective psychological treatment" (Overholser, 2008: 411).

McAdams and Foster (2000) carried out a survey of 376 counsellors to explore the frequency and impact of client suicide. Of the 376, 23% had experienced a client suicide and of that group 23.6% had been students at the time. Similar to previous research on the impact of suicide on psychologists and psychiatrists, strong emotions such as anger and guilt were experienced; however, in this study participants reported greater intrusion of avoidant thoughts about the event than their colleagues in psychology and psychiatry. McAdams and Foster suggest that this may be due to counsellor's training having less emphasis on working with suicidal clients. They suggest that suicidal clients could be screened from student counsellors, but go on to recommend that counsellor training should prepare students for the possibility of working with clients' suicide and ideation. This would then:

"…develop the professional ability to constructively cope with difficult client problems, treatment failures, stressful clinical events such as client suicide" (McAdams and Foster, 2000: 119).

Trimble et al (2000) carried out research on the impact of suicide on psychologists, and reflects that out of a sample of 437 participants 43% (*n* =186) could not recall formal training on their university courses to work with suicidal clients. Of those who could recall having received training 20% (*n* = 89) thought it amounted to 2 hours or less. However, 74% had attended workshops or seminars on the subject.

Sanders et al (2005) highlight the lack of formal training for social workers to prepare them to work with suicidal clients. Similarly Spiegelman and Werth (2005) and Hendin (2006) acknowledged the unmet need for the education of psychiatrists and other mental health professionals who work with suicidal clients. Reeves et al (2004) and Kleespies et al, (1990) suggested that counsellors and psychotherapists are generally poorly prepared for working with suicidal clients during their training.

Foggin et al (2016) carried out qualitative research using thematic analysis to examine GP accounts of supporting patients bereaved by suicide. Their findings highlighted how underprepared GPs felt to deal with suicide, and its effects on bereaved parents. GPs were surprised how emotionally affected they were, and many did not allow themselves the space to consider their own grief. There was also an acknowledgement of GPs working

within isolating and highly stressful environments. Foggin et al (2016) are in the process of developing training resources to support GPs to work within the area of suicide bereavement.

Menninger (1991) suggested that practitioners need to acknowledge their limitations, and to recognise they will not be able to 'save' all patients from suicide. While Grad (1996) suggests practitioners need to be informed during their training, that a patient's suicide can happen to anybody. Grad states that in her opinion, mental health professionals are not adequately prepared for the suicide of a patient. She goes further by writing "they will not be able to save every suicidal patient and that after the death they will not be spared some emotional reactions" (Grad, 1996:141). Having knowledge of the official coroner's procedures is also suggested. Menninger (1991) and Campbell and Fahy (2002) suggest that clinical services should have written guidelines of good practice in the event of client suicide available for staff. They also see this as being an opportunity for staff to reflect and learn from the experience.

2.5 Summary

This review of relevant literature highlights that a significant percentage of practitioners from all professions, settings and stages of their career experience a degree of disruption at a personal and professional level following the suicide of their client. The exception being a small sample of literature which suggests that male practitioners reported fewer disturbances than their female colleagues. Rycroft (2005) sums up the impact from a personal and professional perspective in the following way:

"The realm of 'professional' enters into one's personal life as at no other time, through thoughts, dreams and feelings". (Rycroft, 2005: 87)

Rycroft refers to this as 'burn-in' as distinct from 'burn out' and goes on to indicate:

"our personal vulnerabilities and resources cannot help but enter into our professional lives. The personal and professional become deeply intertwined". (Rycroft, 2005: 87)

There is also a consistency in the emotional themes experienced by practitioners with some professionals going on to experience symptoms of trauma.

Practitioners from a variety of settings reported negatively about their working environment. Practitioners in private practice reported feeling isolated, whilst practitioners in hospital settings felt under threat due to their colleagues' perceived responses. Practitioners in an outpatient setting experienced loneliness and isolation where as those based in an inpatient setting felt they were 'in a fish bowl'. Kolodny et al (1979) sum up this intense sense of isolation experienced by practitioners from all settings in the following way;

"We recognised that, particularly at the beginning, we felt an intense need for support, understanding and absolution, and yet we felt isolated. We realise this was so, in part, because the process of mourning is and must inevitably be a lonely one" (Kolodny et al, 1979: 43).

Although I acknowledge that some environments can be less supportive than they could be, I suggest that the isolation experienced is less about the environment, and more to do with the internal processing which takes place following client suicide.

Those at the early stages of their career demonstrated an openness to reflect on their experiences. Whilst literature outlining the impact on experienced practitioners appeared contradictory with some practitioners purporting to be less affected by clients' suicide or playing down feelings or the presence of emotions, still others clearly were impacted but had assumed their experience would have protected them from such intense emotions.

It would seem that for many practitioners time is a healer, but for others, as reported by Sanders (2005) the elapse of time does not seem to indicate a lessoning of reaction to the suicide. Rycroft (2005) suggests that such trauma symptoms are a sign of humanity and not weakness. Like other life and death events, the impact runs its course with the potential of new- found understanding and growth, both professionally and personally.

Clearly there is a need for practitioners from all professions to receive appropriate preparation through training and support in their work. We need to be mindful that the death of a client is likely to be a challenge to anyone as we are all vulnerable human beings. Litman (1965) highlighted;

"Therapists react to such deaths personally as human beings much as other people do, and also according to their special role in society. Their theoretical, philosophic, and scientific attitudes have a defensive and reparative function and help them to overcome the pain which they feel as human beings and therapists". Litman (1965: 575)

This chapter has reviewed a wide body of literature and in the next chapter I will discuss the methodology of my research.

Chapter Three: Research Methodology

This chapter will outline the rationale for the design of this research study. I will discuss the philosophical, epistemological and methodological ideas which informed my decision-making related to implementing a mixed method pluralist approach.

3.1 Overview

My initial counselling training came from a humanistic view point: this was followed by postgraduate training which encompassed existential, phenomenological, postmodern and psychoanalytical perspectives, and more latterly cognitive behavioural therapy.

I developed an early humanistic view of people being conscious of their behaviour, and striving towards self-fulfilment. However my personal philosophy now is more inclined to think that the unconscious plays a greater part in our thoughts, words and actions (Freud, 2003; Freud, 2005; Symington, 1986; Casement, 2014). This leads me to believe that we all have a tendency to be irrational and contradictory.

I see the language we choose to use as being of great importance in understanding thinking, although the words chosen may have quite different meanings when used by another person. Therefore, I will often ask people to describe what they mean, which helps to prevent me making presumptions as to what they mean. It also allows the other person opportunity to consider their words and meanings, and may enable them to gain deeper insight of their own thoughts. (Bion,1967)

Early on in my career I was more certain and rigid in my thinking: however, as my thinking has matured I have moved further away from positivist perspectives, largely because I have become more aware of how little I really know. I am keen to see peoples' experiences from their own phenomenological and socially constructed perspective. I believe that knowledge is gained from observation, study, experimentation and experience. However, although knowledge provides a degree of understanding, an hour later a different viewpoint may have been reached. It is often said that the only certainty in life is that we will die, therefore I think that 'knowledge' and 'truth' need to be held lightly and regarded humbly. Peoples'

accounts of their thoughts and behaviours may be conflicting, but each account will be their 'truth' at that moment in time.

My own ideas about knowledge are akin to Smith and Sparkes (2008) who suggest that knowledge is:

> ''…socially constructed and always fallible, and, as such, there can be no theory- free knowledge: there are multiple ways of knowing.'' (Smith and Sparkes 2008:178)

Harper (2012) and Harper and Spellman (2014:97) describe how from a social constructionist view point there is "radical doubt about 'taken for granted' knowledge''. They indicate that knowledge is historically, socially and culturally specific. In addition they consider the way that things are explained is never from a neutral perspective, but always comes from the individual speaker's frame of reference.

3.2 Design of the Research Study

Creswell (1994), Creswell (2007) and McLeod (2011) suggest that quantitative research is about numbers and causal linkage between variables, whilst qualitative research starts with language and meanings. Silverman (2000) indicates that quantitative research can amount to a 'quick fix', involving little or no contact with people, whilst Parker (1999) states that qualitative research is 'part of a debate and not a fixed truth'. Parker goes further when he writes that qualitative research is an attempt to 'capture the sense that lies within, that structures what we say about what we do'. He also describes it as an:

> ''…exploration, elaboration and systematisation of significance of an identified phenomenon, and the illuminative representation of the meaning of a delimited issue or problem.''(Parker 1999:3)

Parker (1992) highlights that when research is about quantification it often 'fuels the fantasy of prediction and control'. Whereas qualitative research begins with the starting point of the awareness of the gap between an object of study and the way in which we represent it. He

writes that interpretation acts to fill that gap:

> ''The process of interpretation provides a bridge between the world and us, between our objects and our representations of them, but it is important to remember that interpretation is a process, a process that continues as our relationship to the world keeps changing. We have to follow that process and acknowledge that there will always be a gap between the things we want to understand, and our accounts of what they are like, if we are to do qualitative research properly ''(Parker, 1992: 3).

McLeod (1994) indicates that qualitative research yields rich descriptive material that is both authentic and stimulating, yet alongside this it provides complex and multi-layered material, which may be difficult to make sense of. He implies that the field of qualitative research is methodologically much more fragmented than is the world of quantitative methods.

Initially, I intended to use a qualitative approach -in particular, to use discourse analysis for this doctoral study, reasoning that it was probably the most appropriate having used it for my MSc research study on a similar theme.

In order to consider other research methods and find out which would be most appropriate for achieving my objectives, I considered the following questions:

1. Which approach would effectively allow me to answer my research question?
2. Which approach would enable me to devise robust and meaningful products?
3. Which approach would sit well with my philosophical view point?
4. Which approach would challenge me both personally and professionally?

Whilst discourse analysis suited the earlier MSc study, I sensed that this doctoral research study needed to explore from wider perspectives and achieve more forms of data. Thus the idea of using a mixed method approach appeared to be the most viable way to accomplish the demands of the four questions above.

3.3 Discourse Analysis

Parker (1992: 5) reflects that discourse analysis does more than just describe the social world; in categorising, it brings 'phenomena into sight'. These discourses allow us to see things that are not 'really' there, and that once an object has been elaborated in a discourse, it is as if it were real. Discourse analysis deliberately systematises different ways of talking so that we can understand them better.

Parker (1992) writes of the influence of phenomenology and post-structuralism on discourse theories, and the importance of this for qualitative research. He indicates that the social world is never a closed system, that meaning is continually changing, and that each language is made up of many languages or discourses. Parker refers to the post - structuralist writers as recognising social relationships, and one's sense of self as not being produced by a single structure. Rather, what we do and what we are is created or constituted in such a way that it causes conflict between discourses.

Analysis of discourse is described by Wengraf (2001:7) as being associated with Foucault and Chomsky and is an attempt to identify that which underlies the 'surface performance' of what is said.

Potter and Wetherell (1987) describe a well-defined ten-stage method to carry out discourse analysis.

Having used this approach for my MSc study, I found it to be clearly structured, and it generated a wealth of material from the interviews. However, the identification of interpretive repertoires was problematic, because there appeared to be so many overlaps, and nothing seemed solid or defined. This was in line with the post-modern notion of meaning and sense being just out of reach.

My original desire for the MSc study was to hear therapists' experiences of the effects they had encountered after working with suicidal clients. However, so much of the transcribed material had to be left out of the study, that I experienced a certain degree of violence in the way that I had to dissect the dialogues.

Although discourse analysis had the potential to answer my doctoral research question, I realised that the products I aimed to develop may need more evidence than this approach alone could offer. I felt that whilst elements of the approach did fit with my philosophical view point, I wanted a more expansive approach.

I attended a Professional Knowledge seminar at the Metanoia Institute entitled 'Letting go of certainty: using social constructionism to enrich your research', delivered by Dr David Mair and Dr Denise Meyer. As the day progressed, I encountered a challenge not to go for the 'safe' or 'familiar' approach, but instead to take a 'risk' and 'see things from another perspective'. The analogy I was left with was one of surfing a wave: when surfing a wave you can never predict exactly what the wave will do, or where you will end up. I left the workshop feeling both excited and anxious about the prospect of deliberately upsetting my certainty. I wanted my research journey to be meaningful both personally and professionally, so I embraced the idea of venturing out of my comfort zone, veering away from using discourse analysis and trying something different. If I could allow my own foundations to be rocked it may enable me to have a greater openness to varying viewpoints, positions and different experiences of working with suicide.

Whereas discourse analysis would provide one type of knowledge, by using a mixed method approach I would gain varying types of knowledge, which in turn could be used for the different purposes I required from the study.

3.4 Survey Questionnaire

One of the products I wanted to produce was a training programme. Although there are a number of organisations and individuals providing workshops and training courses on working with suicide, I had identified a number of gaps. Existing training focuses on areas such as risk assessment and management, providing practitioners with largely theoretical knowledge. However, content aimed at enabling practitioners to assess their own beliefs about suicide and to manage their own wellbeing, if mentioned at all, was minimal. I wanted to discover not just practitioners' experiences of working with suicide, but to examine the training that they had found helpful, and to identify in hindsight what may have been missing from their training experience, which could have aided their work with suicidal

clients. If I used a qualitative approach based on analysing interview material- even if I did twenty interviews- I was uncertain that the data would provide a broad enough representation of practitioners' experiences of training. This led me to consider the value of designing a survey questionnaire to collect data on practitioners' experiences from a larger and broader group.

Oppenheim (1992), Jackson and Furnham (2000), French et al (2001) and Denscombe (2003) indicate that surveys are economically effective in terms of both time and money, as a large proportion of research respondents can be reached relatively quickly and easily. They go on to suggest that surveys are particularly useful for gathering information about attitudes and knowledge, they provide quantifiable information, identify opportunities for change or improvement and are able to assess respondents' needs. Respondents' needs are of particular interest as I want the final products to be based on the requirements of practitioners, and relevant to those working with suicidal clients.

Berry and Parasuraman (1991), Jackson and Furnham (2000) and Dahlberg and McCaig (2010) suggest that good surveys measure the right things, are clear, well thought out, user friendly, simple, brief and tailored to the need.

By designing a survey, I could incorporate both quantitative and qualitative questions covering a broad range of issues. The responses to the quantitative questions would generate descriptive statistics, and the qualitative responses would allow insight into specific training needs that could be analysed and used to design a training course based on practitioners needs.

I further decided that thematic analysis would be an appropriate approach to analyse the data from the qualitative open questions.

3.5 Thematic Analysis

Braun and Clark (2006) suggest the advantages of this method include being able to summarise key features from a large body of data, and offer a 'thick description' of the data set. They go on to highlight that the approach can emphasise similarities and differences, along with generating unanticipated insights.

Willig (2013) indicates that good thematic analysis is:

''…the product of a combination of theoretical knowledge and understanding, as well as the ability to systematically yet creatively thematise and interpret data.'' (Willig, 2013:66)

Boyatzis (1998), Fereday and Muir- Cochrane (2006) Crawford et al (2008), Ross and Green (2011) all promote the value of thematic analysis with the data being the driving force.

When data is collected related to the research topic, the themes identified using thematic analysis may bear little relation to the specific questions asked of the participants. They should also not be driven by the researcher's theoretical interest in the area or topic. This is supported by Patton (1990) who implies that identified themes which arise are strongly linked to the data itself. These ideas were particularly appealing to me as I wanted the research findings to be data- driven, and as a researcher to be personally open to the data demonstrating new ideas or viewpoints.

Thematic analysis focuses on the discovery of themes from within the data corpus, and Joffe (2012: 209) describes a theme as 'a specific pattern of meaning'. Themes can contain manifest and latent content: manifest content is that which is explicit, and latent content that which is implicit. Braun and Clark (2006) refer to the manifest content as semantic. Joffe (2012) indicates that manifest themes can point to latent levels of meaning from within the data. Boyatzis (1998) warns researchers to be mindful of the possible pitfall of seeing the manifest approach as an easy option. He goes on to suggest that latent themes will remain out of reach, and rich data may go unanalysed. In addition Boyatzis cautions the researcher that latent level analysis can be extremely complicated, and it is possible to get lost whilst exploring the data.

In addition to manifest and latent content, another feature of thematic analysis is the consideration of themes being drawn from a theoretical view point or the raw data. If analysed with a theoretical viewpoint it is described as deductive. The deductive approach enables the researcher to support what has already been investigated in previous research. However, if the researcher focuses purely on the raw data this is described as inductive.

Boyatzis (1998) and Joffe (2012) promote the value of using deductive and inductive approaches together. This allows the researcher to view the data with preconceived concepts from theories, yet remains open to the possibility of concepts which may be new and thus add to what already exists.

Joffe (2012) emphasises that thematic analysis is one of the most systematic and transparent approaches available, and suggests this is:

''…partly because it holds the prevalence of themes to be so important, without sacrificing depth of analysis.''(Joffe, 2012:12)

Boyatzis (1998) provides a four stage approach for carrying out thematic analysis. Stage one involves recognising a codable moment from the data, and he refers to this as 'sensing a theme'. Stage two involves reliably and consistently coding the moments. Stage three involves developing the codes, and Boyatzis proposes that this phase is developed through repeated practice. Stage four is the phase of interpretation of the information and putting themes in order, to contribute to the development of knowledge.

I had been particularly impressed with research carried out by Frith and Gleeson (2004), who used thematic analysis to examine body image and appearance: in their research paper they indicate their use of Braun and Clark's (2006) thematic analysis approach. There were some similarities with discourse analysis, and I found the step by step description of their model valuable. Table 1 highlights Braun and Clark's six stage approach:

Table 1: Phases of Thematic Analysis

Phase	Description of the Process
1. Familiarising yourself with your data	• Transcription • Reading and re-reading • Noting initial ideas
2. Generating initial codes	• Coding interesting features of the data in a systematic fashion across the entire data set

	• Collating data relevant to each code
3. Searching for themes	• Collating codes into potential themes • Gathering all data relevant to each potential theme
4. Reviewing themes	• Checking if themes work in relation to coded extracts • Generating a thematic map of the analysis
5. Defining and naming themes	• Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells • Generating clear definitions and themes for each theme
6. Producing the report	• Section of compelling extract examples • Relating back to research question and literature etc.

Within the field of psychology there is still some scepticism with regard to qualitative methods and the perception that it can be less scientific and not real research. Whilst I personally do not hold that viewpoint, I consider that qualitative thematic analysis uses rigour and transparency. Braun and Clark's method allows stage by stage openness as to how themes are discovered, checked and developed. Joffe (2012) suggests that thematic analysis allows the researcher to be faithful to the data while being systematic in approach. Another aspect which appealed to me was the indication that good thematic analysis allowed for the data corpus to be analysed, and not just small samples: this felt particularly important with regard to validity and quality.

3.6 Narrative Approaches

The second product I wanted to create was a book containing the accounts of practitioners' who had experienced client suicide at first hand. The compilation of stories would each provide a glimpse of the challenges of working with client suicide. Although I had read a considerable amount of relevant material, I had not come across a book such as this reflecting the honest accounts of this challenging aspect of work faced by practitioners. I believed it would provide readers with a side of therapy rarely spoken about or seen, with each chapter outlining a different practitioner's story, illustrating survival, hope and resilience.

In the early days of the research journey I came across a paper by Bond (2002), entitled 'Naked narrative: real research?' The aim of Bond's paper was to consider the challenge of researching the lived experience, and how it can be distorted by traditional approaches. Bond outlined a narrative account of his own experience of ethical decision making within a supervisory relationship. Bond (2002) compares natural scientific approaches to the narrative approach and concludes:

''The systematic use of narrative opens up the possibility of studying lived experiences more directly and creates new challenges in how to communicate new insight to readers.'' (Bond, 2002: 137)

Bond's account demonstrated a detour from his normal practice; it showed honesty, vulnerability, reflexivity and a preparedness to do research in a different way. These characteristics were appealing, and I was intrigued by the idea of generating such rich accounts of practitioners' stories for my own research.

I was also reminded of Axline (1964) and Yalom (1989) who both used a narrative account to demonstrate their research findings. As the ideas for my final products began to formulate, it also became clear that in order to make them a reality, the design of this study would be crucial.

Labov (1972), Mishler (1986), Frank (1995) and McLeod (2006) all promote the benefits of using a narrative approach, with a key attraction being that interviews are kept as intact

narratives. Polkinghorne (1995), Chase (2005) and McLeod (2011) describe how the narrative approach encourages informants to tell their stories, and provides an understanding of different experiences and themes. These themes can be viewed as 'typical' of broader themes from within the data.

McLeod (2011) states that:

''The key idea in narrative analysis is that people largely make sense of their experience, and communicate their experience to others, in the form of stories.'' (McLeod, 2011: 187)

Riessman (1993: 2) suggested that narrative analysis examines a story to see how participants' '…impose order on the flow of experience to make sense of events and actions in their lives'.

Later, Riessman (2008) highlights that :

''…storytelling engages an audience in the experience of the narrator. Narratives invite us as listeners, readers and viewers to enter the perspective of the narrator'.'' (Riessman,2008: 9)

She goes further by indicating that:

''…the story teller can pull the reader into the story world – and move us emotionally through imaginative identification". (Riessman, 2008: 9)

I believed that each of these aspects boded well for my first product of a book outlining practitioners' accounts.

I considered Labov's (1972) model of narrative structural analysis. This approach entails collecting the participants' stories, and then organising them round a six phase structure. The first phase is known as the **abstract**, and is identified when the narrator speaks of the summary or point of the story. This is followed by the **orientation** which states time, place, situation and characters involved. The next phase is known as the **complicating action** and it is here that the narrator outlines a key event, usually with a crisis or turning point. The next phase is the **evaluation**, and this occurs when the narrator steps back from the action and comments on the meaning and communicates emotions. This is followed by the **result or**

resolution which is the outcome of the event. The final phase is known as the **coda** and it is at this phase that the narrator ends the story and brings the action back to the present.

A strength of this approach is that it provides the researcher with tools to unpick how participants use speech to construct their story and their world. I planned to use this model for quite some time, but as I read further I began to recognise that it was not the construction of the story I really wanted to understand, but the story itself. If I were to follow Labov's structure, it may cause me to focus so intently on these six phases that the overall story may become secondary. It also became apparent that structural analysis may not be suitable for larger samples. As I wanted to interview multiple participants to ensure I gained enough material to produce a book, I became less certain about using Labov's model.

I also felt a reluctance to use a method which would dissect the narrative. I wanted the story to stand in its own right- like Bond's (2002) naked narrative -and allow the reader or hearer to make up their mind about what it meant to them. However, I acknowledged that as part of my doctoral research I would need to use analysis in some way.

It was at this stage that I became aware of Mishler (1986) and his use of narrative analysis. A distinction he makes is to focus on the story as spoken by the participants, rather than the process of how the story is told. An asset of this approach is that it enables a biographical narrative to emerge from the narrator, rather than focusing on the dialogue between narrator and researcher. Riessman (2008: 59) suggests that narrative analysis views 'language as a resource rather than a topic of inquiry'. This principle is also highlighted by Ewick and Silbey (2003) when they state that the purpose is to gain understanding of the meaning and purpose of the stories contained in interviews.

Riessman (2008) stresses that the importance of narrative interviewing is to 'generate detailed accounts rather than brief answers or general statements'. She indicates the need for the interviewer to commence by encouraging the participant to tell their story. This can lead to the narrator giving stories within stories, and for the interviewer to follow the narrator thus giving up control of a fixed interview format. This can allow for higher levels of equality between interviewer and narrator but also greater uncertainty for the interviewer. (Riessman, 2008: 23)

Silver (2013) indicates that narratives produce knowledge about how people:

''…weave their experiences into meaningful stories, and about some of the (psychological and social) consequences of this.'' (Silver, 2013: 152)

The approach also considers how participants construct their story, what they included, what they may exclude and what their stories mean to them. Narrative research would seem to produce social constructionist knowledge.

Silver (2013) goes on to suggest that people are reflective, natural storytellers, who make these experiences meaningful by telling stories about them. It would seem that as people tell stories, their involvement in the story telling process is a way of discovering who they are, and making sense and meaning from a social context. The way in which people experience themselves in the world is the product of the narratives they construct.

After deliberation I opted for follow Riessman's (1993) five stage approach in which she describes the levels of representation of experience as outlined in Figure 1.

The first stage of the process is known as **attending to the experience**. This is the actual lived experience, in which participants would have worked with their suicidal clients. Attending refers to their reflecting, remembering and recollecting their observations, leading to certain phenomena become meaningful. Participant's meaning will be dependent on their acknowledged and unacknowledged beliefs and values.

The second stage of the process is the **telling of the story**. As participants recount their stories to me they will provide context, description and together we produce a narrative. Riessman (1993) highlights that:

''In telling about an experience, I am also creating a self – how I want to be known'.'' (Riessman, 1993: 11)

I believe that this is an important factor, and in planning felt that it could provide rich insight for my research products.

The third stage of the representation process is **transcribing**. I was initially perturbed to read that Riessman (1993: 11) described transcribing as 'incomplete, partial and selective'.

However, transcription is never an exact interpretation and is always theory driven. There is a significant overlap between the third and fourth stages of this approach and Riessman (1993: 8) refers to this process as having 'porous boundaries'.

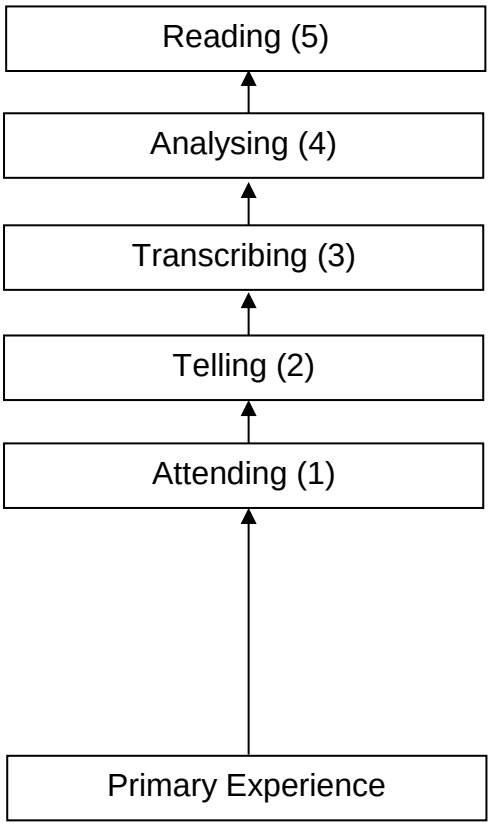

Figure 1: Levels of Representation in the Research Process

The fourth stage is when the researcher **analyses** the transcripts. This is not a one off occurrence, but requires repeated readings of the transcripts. It is during this stage that the researcher identifies themes across the data resulting in a 'meta story' being created through reading and construction. Riessman (1993: 13) refers to this as the 'hybrid story'.

Denzin (1989) suggests that this interpretive biography method can describe turning point moments in an individual's life. These are also referred to as 'epiphanies' or 'moments of revelation' and can often have left a mark on the life of the narrator.

Riessman (2008: 50) implies that the decision making at this stage is driven by 'theoretical commitments (and practical constraints); they are not simply technical decisions'. Previously Riessman (1993) recommended that analysis of the narrative data should start with questions, such as 'How is it organised? or 'Why does an informant develop her tale in this way with this listener?' Riessman (1993) went on to highlight the need to:

''…start from the inside, from the meaning encoded in the form of the talk, and expand outwards.'' (Riessman, 1993: 61)

During the analysis the researcher should pay attention to social, cultural and institutional discourses which may come to light.

The fifth stage is known as the **reading experience** and is the time when the final report is available to be read. Reissman (2008) cites Rabinow and Sullivan (1979/1987: 12) when she refers to the fact that 'every text is '…plurivocal', open to several readings and to several constructions'. By using this version of narrative analysis on each of the transcripts I believe the results will act as a foundation for the book containing practitioners' stories. However, the truth and meaning of my final report and products will be different to each individual who encounters it.

In my quest to gain multiple types of knowledge and formulate products which would be meaningful to practitioners, I chose to analyse the data from a further perspective. In addition to carrying out a narrative approach on each of the interview transcripts, I would also combine this approach with Braun and Clark's (2006) use of thematic analysis in order to compare the data across all of the interview transcripts. Figure 2 shows a summary of the research methodology I used for this study.

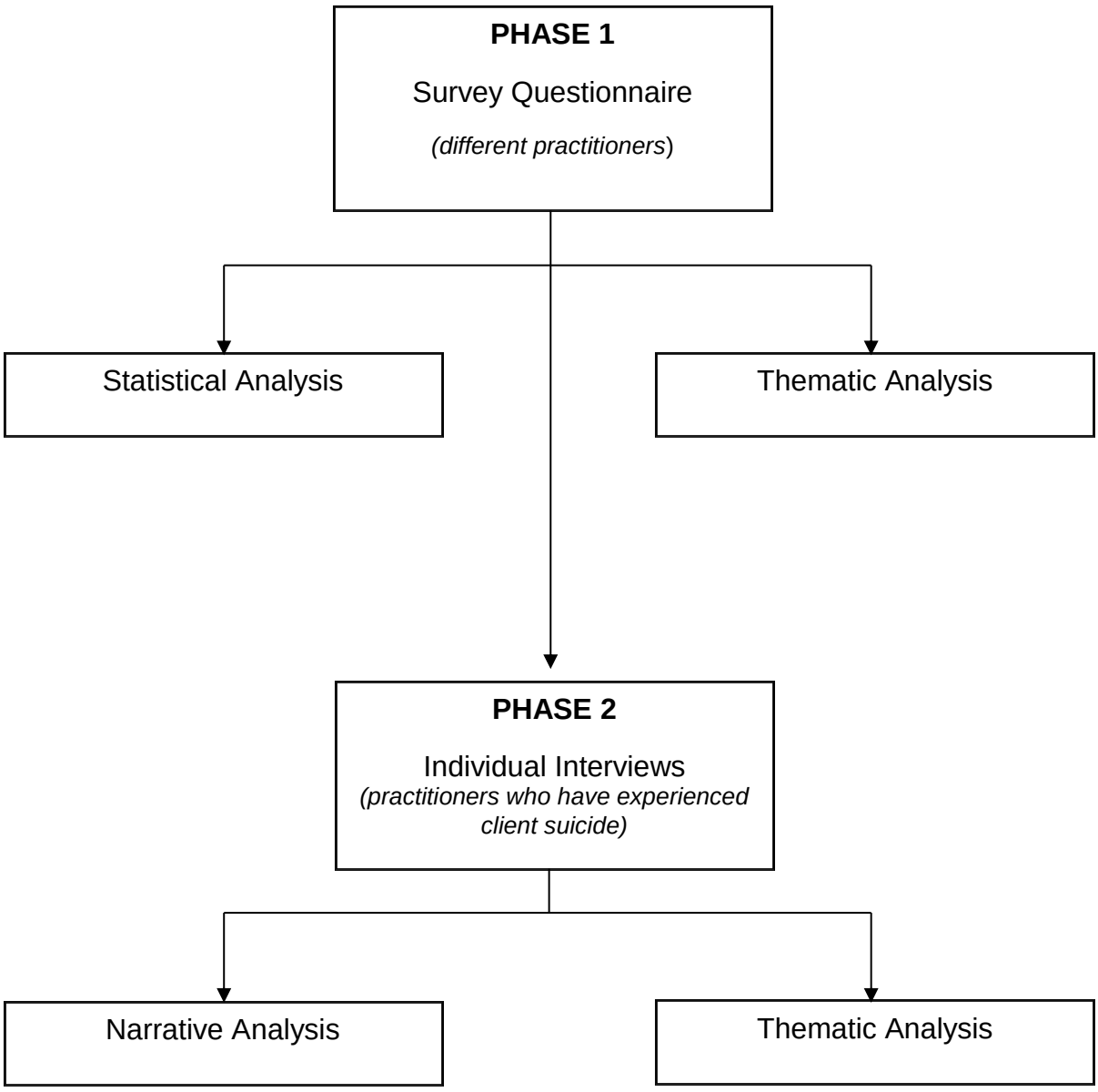

Figure 2: Summary of the Research Methodology

3.7 Mixed Methods

By using a mixed method approach, I considered that both of my main products would have a greater chance of a successful outcome. Polkinghorne (1984), Goss and Mearns (1997) and Haverkamp et al (2005) state that mixed method research is unique, in that it brings both forms of knowing together at the same time. Haverkamp et al (2005: 124) liken quantitative

research to photography in which images are produced 'characterized by precision'. Qualitative research is described as painting a portrait which "can offer a glimpse of what resides beneath".

Similarly, Frost et al (2010) and Harper (2012: 93) indicate that mixed methods can 'illuminate another layer of the topic' along with different elements of the same data set. Bryman (2006) and Brannen (2007) outline that convergence and corroboration using different methods can bring significant benefits. Results from different methods can also become complementary, thus providing clarification for example from one method can be developmental in informing a second method's data, or highlighting discrepancies and new perspectives. By using more than one method my research will have a breadth and range of enquiry which a single method of research would lack. Madill and Gough (2008) posit that pluralism can highlight the limitations of one method which can compensate and become strengthened by a second method.

Hesse - Biber (2010) emphasise that:

''Conducting a mixed method study can enhance the validity and reliability of findings as well as allow for the exploration of contradictions found between the quantitative and qualitative results.'' (Hesse – Biber, 2010: 456)

It may also be possible in using a mixed method approach, to evidence the findings from the two phases of research to identify a triangulation of sightings taken from multiple perspectives from within the body of data.

Rogers and Apel (2010) make the specific request for more research to be carried out using mixed methods in the area of suicidology. Goldney (2002) suggests that in suicidology neither qualitative nor quantitative research alone is adequate; instead he indicates that both approaches are necessary to adequately consider the subject matter.

Green et al (1989) and Bryman (2007) make interesting observations with regard to the extent to which researchers using a mixed method approach analyse and write up their research. Bryman (2007) suggests that some research is reported 'in such a way that quantitative and qualitative components are mutually illuminating'. He suggests that mixed

methods studies have the opportunity to 'talk to each' and that researchers can 'construct a negotiated account of what they mean together'. (Bryman, 2007: 8)

Harre and Crystal (2004), Creswell, Plana and Clark (2007), and Creswell (2009) highlight that mixed methods research is more than collecting and analysing quantitative and qualitative data. They purport that using both approaches together strengthens the research making it more robust than either quantitative or qualitative research alone.

3.8 Summary

Deciding to work pluralistically would provide greater transparency and allow the data to be analysed in multiple ways, to be reflected upon, to be considered for potential insights which may not have been possible without such full investigation. It would also allow me to answer my research question, and a mixed method approach would yield sufficient data to meet the requirements I needed to devise robust and meaningful products. It was also congruent with my philosophical view point and would certainly challenge me both personally and professionally.

In the next chapter I will outline the details of my research method and data analysis method.

Chapter Four: Research Method

In this chapter I will outline the methods used to carry out my research study, along with considerations of the ethical issues, quality and validity.

Following ethical approval for the research proposal from the Metanoia Institute and Middlesex University Programme Planning Panel (Appendix A), I contacted Berkshire Healthcare NHS Foundation Trusts (BHFT) Research and Ethics Department who confirmed Trust Management Approval (Appendix B) for my research.

Table 2 shows the actual stages of my research journey, and if compared to the proposed timeline in my Learning Agreement, demonstrates that I significantly underestimated the time it would take to analyse and write up the thesis. I was surprised how many layers of data and processes I went through as each chapter was formulated.

Table 2: Stages of the Research Study

Phase One	
January 2014	• Following feedback from the Ethics Committee and Metanoia Programme Planning Panel make any amendments required • Finalise quantitative survey and implement a pilot amongst critical friends • Act on received feedback • Ensure survey design is fit for purpose • Gain agreement from Academic Advisor to proceed
April 2014	• Activate survey on Smartsurvey.com

	• Email practitioners on registers such as BACP, BABCP and colleagues on contact lists whom I have met at conferences on suicide inviting them to take part in the survey
May 2014	• Contacted BACP to arrange for the survey to be placed on their Research Noticeboard and an advert was placed in Therapy Today
June 2014	• Therapy Today advert went live
August 2014	• Close survey • Data collection, analysis and results • Identify practitioners who had expressed an interest in taking part at Phase Two
September 2014– January 2015	• Initial analysis of the survey took place • Commencement of statistical analysis of quantitative survey data
Phase Two	
September 2014 – January 2015	• Select suitable practitioners to take part in qualitative interviews • Email practitioners and invite them to take part

	• Practitioners to be contacted and discuss Phase Two, carry out risk assessment via phone or email • Arrange interviews • Carry out recorded interviews • Debrief participants
October 2014 – February 2015	• Transcribe audio recordings • Discussion of transcripts with research assistant • Debrief research assistant • Check transcripts for accuracy
March 2015	• Commence thematic analysis of qualitative survey data
April – June 2015	• Study leave • Commence narrative analysis of interview transcripts • Commence writing thesis
July 2015 – September 2015	• Commence thematic analysis of interview transcripts
October 2016	• Inform Metanoia of January submission • Submit Professional Knowledge Seminar essay
January 2017	• Submit final project

Phase One

4.1 Implementation of the Survey

I consulted with Stephen Goss, my Academic Advisor and other critical friends to finalise the survey questionnaire, and in January 2014 ran a pilot study with six colleagues who I trusted to provide me with honest feedback, in order to test its' fitness for purpose. This was followed by making relevant amendments prior to activating the survey on the Smart Survey website in April 2014. I had experimented with a number of survey websites, but chose Smart Survey in preference to other packages due to the sophisticated analysis it provides along with ease of use and customer support.

The questions for the survey were devised in order to gain sufficient information to meet the aims of the research study, and contribute to the development of robust products. The finalised survey was made up of a combination of 26 closed and open questions (Appendix C). Prior to commencing the survey participants were shown a statement outlining the need for their consent, and only if they agreed with the aims and indicated their consent were they able to continue with the survey.

The initial questions in the survey were based around demographics such as gender, profession and settings in which the practitioner worked. This was followed by a series of questions to establish their experience of working with clients who had had suicidal ideation, made attempts or taken their life by suicide. Depending on the practitioner's answers, the survey used skip logic to take practitioners to the next relevant section of the survey. The survey questions then invited practitioners to consider their thoughts and emotions in relation to these events, adjustments made to their work pattern, training preparation to work with suicidal clients and support received from managers and supervisors.

The final questions in the survey asked practitioners whether they would be willing to be individually interviewed, and to speak further about the impact of their work with suicidal clients; if they were in agreement they were asked to provide contact details.

In May 2014 I contacted BACP to arrange for the survey to be placed on their Research Noticeboard and an advert was placed in the June 2014 addition of *Therapy Today*

(Appendix D). In May 2014 I began to email practitioners on registers such as BACP, BABCP, and counselling organisations to introduce myself and the research study, and inviting them to participate in the research (Appendix E). As I work BHFT, I also informed senior managers within the Trust of the research study and asked whether they would be willing to cascade the survey to their staff teams. In all, emails were sent to 358 individuals and organisations during the period of May- July 2014.

Because I wanted the survey to provide rich data, I was keen that qualified and trainee practitioners would complete the survey, those who have experienced client suicide and those who had worked with clients speaking of suicide. I also desired to include practitioners from a range of theoretical orientations and work settings.

By contacting possible participants via email I was using convenience sampling, in that I was targeting a particular cohort such as psychotherapists: in addition I used purposive sampling. Patton (2002), Polkinghorne (2005) and Morrow (2005) suggest the importance of purposive sampling. Morrow (2005) states that:

''…qualitative sampling is always *purposeful* – that is, participants are deliberately selected to provide the most information rich data possible.''(Morrow, 2005:255)

I was keen to have a large number of practitioners contribute to my research in order to increase its' validity. (I believe there was a 'snowballing effect' as practitioners passed the survey link on to other colleagues.)

The survey remained open from May - August 2014 during which time 181 practitioners visited the site and 110 completed the survey.

4.2 Quantitative Data Analysis of the Survey

An initial analysis of the survey took place during September 2014 to establish general content, and to ascertain which practitioners would be invited to take part in phase two of the research. However, a more in depth analysis took place later between January and March 2015.

Having used the online tool Smart Survey to create my survey I was easily able to generate results and reports. The results were presented in the form of descriptive statistics and graphed information which I downloaded.

For each of the closed questions the descriptive statistical information showed how many participants' had answered each question, how many had skipped the question and also provided these numbers as a percentage. For each question the mean, standard deviation, standard error, satisfaction rate and the variance was calculated.

The **mean** measured the central tendency i.e. the scores were calculated and the total divided by the number of entries. **Standard deviation** is the measurement of dispersion which gives an indication of the average difference from the mean, whilst **standard error** is the measure of dispersion equal to the standard deviation divided by the square root of *N (total no. participants).* **Variance** is the measure of dispersion equal to the square of the standard deviation (Brace et al 2012). The **satisfaction rate is calculated** by dividing the total value with the maximum possible total value, and then multiplying by 100 to give a percentage. This percentage is then applied as the satisfaction rate for the question (smartsurvey.com).

Table 3 is an example of how the descriptive statistical information was presented in the online results.

Table 3: Example of Survey Results Presented for the Online Survey

Question 14 **Were you a trainee practitioner or qualified at the time your client took their own life?**								
							Response Percent	**Response Total**
1	Trainee						23.53%	8
2	Qualified						76.47%	26
Analysis	Mean:	1.765	Std. Deviation:	0.424	Satisfaction Rate:	76.47	answered	34
	Variance:	0.18	Std. Error:	0.073			skipped	76

The data in Table 3 shows that *n* =110 of which *n* = 34 had experienced client suicide. Of that number *n* = 8 had been trainees and *n* = 26 had been qualified. As a percentage this equated to 23.53% of the participants being trainees when their client took their own life and 76.47% were qualified.

The online Smart Survey analysis also facilitated cross tabulation. Table 4 shows an example of cross tabulation for question 3 on practitioners' profession, and question 11 which asked if they had had experience of client suicide.

Table 4: Cross Tabulation of Question 3 and Question 11

	Have you had experience of a client taking their life by suicide?			
Professional title		Yes	No	Row Totals
	Counsellor	8 21.05%	40 42.55%	48 36.36%
	Drugs and Alcohol Worker	1 2.63%	0 0%	1 0.76%
	Mental Health Practitioner	4 10.53%	3 3.19%	7 5.30%
	Nurse	5 13.16%	2 2.13%	7 5.30%
	Psychiatrist	1 2.63%	0 0%	1 0.76%
	Psychologist	1 2.63%	6 6.38%	7 5.30%
	Psychotherapist	13 34.21%	30 31.91%	43 32.58%
	Social Worker	1 2.63%	1 1.06%	2 1.52%
	Other (please specify):	4 10.53%	12 12.77%	16 12.12%
	Column Total	38 28.8%	94 71.2%	132 100%

Table 4 shows the breakdown by profession, although it should be noted that a number of participants indicated they had more than one profession. e.g. some counsellors and psychotherapists identified themselves within both of those categories. In hindsight, it may have been more prudent when designing the survey to ask participants to tick only one category. The data also shows that the majority of participants would class themselves as counsellors or psychotherapists. Whilst this is valuable if I only wanted to consider these professions, it represents a potential bias in the data which could be problematic, and will be discussed further in subsequent chapters.

Another possible weakness is that when I designed the survey I had little idea of what the statistical data would look like when I came to analyse it. I found that although the statistical package could do many numerical tasks, it was complex and provided detail that I did not necessarily require.

I will examine the findings from the quantitative data in chapter five.

4.3 Qualitative Data Analysis of the Survey

There were 11 open questions on the survey, and participant responses generated 22,000 words. Thematic analysis was used to analyse the practitioners' responses.

The method I used was based on Braun and Clark (2006), as summarised in chapter three, and I commenced by using an inductive approach, chosen because I wanted the themes to come directly from the survey data. It was important for me to see the responses of the practitioners regardless of the content. Whilst I recognise my part in the selection of themes, I endeavoured to report the data for what it was even if it was unexpected, odd, or opposed to my personal beliefs and values. In addition, I made the decision to examine the data with a semantic lens rather than a latent one. Braun and Clark (2006:84) suggest that the implications of this style means the data is considered at a surface or explicit level rather than 'anything beyond what a participant has said or written'.

Stage 1 of this process began by downloading the raw data from the online survey for each question and saving it as a document. I then read through all the participants' responses to gain an overall perspective of the content for each question. This was a lengthy procedure

due to the volume of material, and also because the data was not always easy to read due to spelling mistakes, grammar, lay out and/or repetition.

Once familiar with the overall data for a particular question I moved on to stage 2 which entailed identifying initial codes. During this stage I made notes on the document as I came across potential codes. Braun and Clark (2006:89) advise to code extracts by including 'surrounding data' as the context can be lost. An example of this stage can be found in Appendix F which shows the data from question 16 of the survey. I reread the list of possible codes, then transferred the codes on to a table in a second document: an example can be found in Appendix F.

At stage 3, I reread the list of possible codes in order to identify potential themes, and sorted codes accordingly. Braun and Clark (2006) refer to this process as making the links between codes, themes and sub themes. Appendix F has an example of stage 3 from my analysis for question 16.

Stage 4 of the analysis took the form of reviewing the themes, and this was carried out at two levels. The first level involved going back to the extracts for each possible theme and examining them to see if they formed a clear pattern. If this was the case I then moved on to level 2, but if not, I went back to the extract to reconsider its content. In some cases a new theme was devised to fit the extract more adequately, and in other cases the extract was moved to an alternative existing theme. Appendix F has an example of stage 4 from my analysis.

Once satisfied that this stage was complete I formulated a thematic map. Braun and Clark (2006) imply that at Level 2 the thematic map should accurately reflect the overall meaning of the data set as a whole.

Stage 5 involved defining and naming the themes. It required a detailed analysis being written for each theme, along with the 'story' that the theme was telling. At this point, sub themes or themes within a theme may become apparent. Braun and Clark (2006:92) suggest that these can provide a 'structure to a particularly large and complex theme'.

I used thematic analysis to analyse the 11 open questions from the survey and then went on to phase two of the research.

During September 2014 I read through all the survey data and grouped participants into those who were and were not willing to be interviewed further. I then grouped participants into those who had experienced client suicide and those who had not.

Phase Two

4.4 Sample Selection

The survey data revealed that 67 participants had indicated they would be willing to take part in interviews, and of that number 37 individuals were contacted via email and invited to an interview (Appendix G). The reason for not inviting the other 30 individuals was due to limited information in their survey answers, or the fact that I knew them in some capacity (which may introduce personal bias in interpretation of their responses).

From the 37 individuals contacted 20 agreed to be interviewed, but 4 withdrew before the interview took place. The remaining 17 individuals either declined to be involved any further or did not respond to my emails.

With regard to sample size Patton (1990) suggests that information richness from the data is more important than a particular sample size. Morrow (2005:255) outlines that data needs to be gathered until the 'point of redundancy, which means that no more new information is forthcoming from new data'. As one of my products would require chapters containing detailed accounts of practitioners' experiences, I sought to interview as many practitioners who were willing, in order to ensure sufficiently 'rich' data.

4.5 Implementation of the Interviews

Following signed consent forms (Appendix G) being received, interviews were arranged either face to face or via Skype, and the interviews took place between September 2014 and January 2015.

Participants were interviewed at a location and time of their choosing. Six participants chose to be interviewed at their place of work, eight chose their home and two via Skype. Each interview lasted for approximately one hour.

Of the sixteen participants (two male and fourteen female), eleven had experienced client suicide and five had worked with clients who had made suicide attempts. Their professions were counsellor, psychotherapist, psychologist, social worker, psychiatrist, support worker, nurse, drugs and alcohol worker and supervisor. The settings that they worked in were private practice, primary care, secondary care, voluntary sector, hospice, drug and alcohol service, Child and Adolescent Mental Health service (CAMHS) and an in -patient ward.

At the start of each interview I checked the practitioner's understanding of consent, and reiterated information outlined in my emails and information sheet. I then enquired whether the practitioner had any questions before commencement of the interview.

In line with the narrative approach, I invited participants to tell their story of working with suicidal clients. In my opening sentences, it was important to convey to the participant that I wanted to hear their stories- that I did not have set questions and that there was not a right or wrong way to tell their stories. Riessman (1993) suggests that this less structured method allows greater control to the participant. Riessman (1993) suggested devising an interview guide (see Appendix H) of 5- 7 questions about the topic in case the participant has difficulty getting started. This was something I used with some participants.

In some cases the participants needed a little time to settle their thoughts, as there was a degree of anxiety and cautiousness. As an experienced therapist I used my skills to allow the participants' time to consider where they wanted to begin. For some it was the first time that they had spoken about the experience to anyone other than their supervisor; for others there was a caution about what to share, and feeling exposed. In some cases, it was the first time speaking about their client to someone sat in the same chair that their client had sat in.

Some participants experienced intense emotions as they spoke, others struggled to think clearly, whilst others recounted different material to that which they had mentioned in the survey, and for some I sensed that they were avoiding some aspects of the story. Craib (2002:174) indicates that in the telling of "life stories there is as much to conceal as to

reveal". Craib (2002) goes on to suggest that leaving out of elements of the narrative is to protect one's self against certain aspects of truth.

The findings from the interviews are outlined and discussed in subsequent chapters.

At the end of each interview I invited participants to reflect on their experience of the interview. Following the interviews, I also took time to personally reflect on my own experience and noted my own thoughts and feelings in my research journal.

4.6 Narrative Analysis of the Interviews

I followed Riessman's (1993) approach to narrative analysis as outlined in chapter three. Transcription of audio recordings took place between October 2014 and February 2015, and was undertaken by a research assistant. Prior to her transcribing the recorded interviews, I had outlined the way in which I wanted the transcripts to be presented, and the amount of detail I required. Names and other identifiable information were changed on the transcripts to protect the participants and their clients. Following each transcription I listened to the audio recording to check the transcript for accuracy.

Between April and June 2015 I took part- time study leave in order to commence the data analysis process.

Following transcription of the audio recordings and the initial reading of the data, I made notes on the transcripts using text boxes and track changes (see Appendix I). I wrote a brief introduction to each of the participants, which included a short outline of the participant's role and details of our meeting. As I became familiar with the transcripted interview, I made notes on the overall structure of the story, the co-construction between the participant and myself, and the various voices and themes within the story.

Each transcript had a selection of stories, or stories within stories. I looked for the way that the practitioner's narrative demonstrated social, cultural and institutional discourses. I then noted on flip chart paper the essences of each practitioner's unique account or Meta story (see Appendix I). During this time I noticed within myself a reluctance to move on to the next stage of research, because I felt an imperative to relay the practitioners' narratives with sensitivity.

Due to the large amount of data obtained, I decided to analyse only the eleven transcripts from those participants who had experienced client suicide. The remaining five were saved to be analysed at a later date, and to be used to produce an article on the impact of suicidal ideation and attempted suicide on practitioners.

The findings from the narrative analysis are outlined in chapter six.

4.7 Thematic Analysis of the Interviews

Once the narrative analysis was complete, I moved on to use thematic analysis across all of the transcripts. I followed the same process that I had used earlier with the open questions on the survey, except for one changed aspect which was to use a latent level rather than a semantic one. Braun and Clark (2006) suggest that the latent level goes beyond the semantic and begins to:

"…identify and examine the underlying ideas, assumptions, and conceptualisations and ideologies that are theorised as shaping or informing semantic content of the data.''(Braun and Clark, 2006:84)

I believed that this would provide another perspective to the research data and hopefully shed light across the whole data set.

The question at the forefront of my mind as I began this stage of analysis was –'What was the impact of the client's suicide on the practitioner?'

The findings from the thematic analysis will be discussed in chapter seven.

4.8 Quality, Validity and Ethics

I have endeavoured to follow Elliott et al (1999), Stiles (1993), Yardley (2000) and Morrow's (2005) guidelines for validity, quality and ethics in relation to quantitative and qualitative research. I shall outline my thoughts about these critical areas under the headings of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance as proposed by Yardley (2000).

4.8.1 Sensitivity to Context

I completed my MSc in 2004 in which I focused on the same subject area, and since that time I have continued to familiarise myself with relevant literature. Theoretical context is an important factor, and as I have considered the body of literature I have identified similarities, differences and gaps in this research area, and appreciated the opportunity to reflect on what has already been formulated. As a researcher it is crucial to not see one's own research in isolation, without taking into account the wealth of material already available.

I have attended suicidology conferences where I have been able to take part in workshops, symposia, research presentations and debates. This has enabled me to be part of the latest research interventions, and to hear from the world leaders within the area of suicide prevention.

I am aware of the debate which has taken place over the past decade as to the value of quantitative and qualitative research in the field of suicidology, along with hesitation from some journals to accept qualitative research articles.

I have kept a data base summary of every book and research paper that I read from 2011 highlighting content, categories and relevance. This was invaluable when I came to write up my research report.

With regard to empirical sensitivity, I have sought to consider the data with an open mind, despite some aspects of the data being unexpected or conflicting with my own views. On these occasions I endeavoured not only to make reference to the dilemma, but to examine, reflect and report on it fully.

In addition, I recognised that the data is more than just information- it represents the participants' perspectives. There were moments during the recruitment of participants', analysis of the survey data, and during interviews when I was personally challenged. I recall moments of anger and concern when my own vulnerabilities or personal beliefs were confronted. It is extremely difficult to be completely unbiased, but I sought to report my incongruence whilst being sensitive to the differing perspectives of some participants.

Ethics is a key area to consider with any research project, but Renzetti and Lee (1993), French et al (2001) and Harper (2008) suggest that additional care should be taken when the subject material is sensitive -such as suicide. It was essential that those taking part in my research were not harmed in any way by the experience. French et al, (2001) state that:

''…to conduct research is to become involved in people's lives. The experiences of research participants cannot be divorced from the responsibilities of researchers or from researcher/participants relationships'.'' (French et al, 2001: 47)

This sense of responsibility and involvement with the participants life was something I felt very keenly particularly during the analysis stages at both phase one and two.

Participants were all provided with detailed information about the nature of the research, and were required to give informed consent in order to take part. At phase one participants were informed that they could choose not to answer any of the questions in the survey, or could withdraw from it at any time without giving a reason. I also provided helplines in the literature in case participants did become distressed and required further support.

At phase two, consent to participate was both written and verbal. Prior to all of the interviews I discussed and clarified the nature and process of the research to ensure that participants had full understanding of what would be covered.

Smith (2000: 17) writes that 'narrative research can be an emotionally fraught process.' Some participants showed emotional distress during interviews, some demonstrated increased disorganisation of their thoughts, unsteady voices, physical shaking, feeling cold, increased nervous activity or becoming silent'. As the researcher I had a responsibility to anticipate and provide support for participants who become distressed during the research process. Some of my participants did find recounting their stories very challenging, experiencing distressing thoughts, memories and emotions. However, as a therapist I have years of working with clients expressing intense emotions, and so despite feeling moved by what was being recounted, I was also confident in my ability to manage the situations with respect and compassion. At the end of each interview when I requested feedback from practitioners, part of my rationale was to ensure that the participants were fully grounded and able to be left safely.

It was essential that all participants gave informed consent and took part in the research of their own volition. I also ensured that I did not interview any one with whom I worked, because it was important for participants to be able to speak freely, without being concerned about repercussions due to dual relationships.

Confidentiality and the storage of material was also an important factor, and all personal details and recordings were stored securely and participants' anonymity protected. This is in line with the Data Protection Act (1998), BACP (2013) and BACP (2016). While Haverkamp (2005) draws attention to the intrinsic need to protect participant anonymity.

During the writing up of my research, in presentations and training I delivered, and in publications, I was careful to ensure that biographical details and changes to those details were done sensitively. With narrative accounts it is particularly necessary to change certain details in order to protect participants, their clients and the organisations they work for. Careful attention to ethics on my part was vital not just for the wellbeing of participants, but also for the research itself and the trustworthiness of the final products. However, in making changes it was important for the integrity of the work not to cross over into becoming a work of fiction rather than robust research.

As a researcher, I was also mindful of the need for personal safeguarding against being overwhelmed by multiple stories of suicidal experiences over many months. Having the support of my Academic Advisor, Consultant and peers to aid me in this process was essential. I used these people to discuss aspects of my work and to safeguard against 'adverse risks' for both the research participants and myself (BACP 2016).

I have a tendency to become immersed in projects such as research, and in the light of this I also needed to be accountable to my family to ensure that my work life balance was appropriate. I arranged with my employer to take 3 months part time study leave. During this time I met with a personal trainer to support me with regular exercise and healthy eating. I thought it would be important for me not to be sat at a desk every day engrossed in my research and the subject of suicide. I also made a conscious effort to socialise even when I felt reluctant, and to regularly visit my children.

4.8.2 Commitment and Rigour

I have already written about my commitment to engaging with literature and attending conferences to gain a greater understanding of the impact of suicide. However, as a researcher I have also read widely on research in general, and more particularly on method/ methodology. As a therapist I have personally supported clients who have experienced suicidal ideation and attempted to take their life by suicide. As a manager, I have given the news to staff that their client has taken their life, and then supported them through the process of loss and adjustment. Under the Duty of Candour process within the NHS I have visited the family of deceased clients to offer condolences, and to outline the investigation process. In addition I have been appointed as an investigating officer for other NHS services who have had a client suicide. This also required me to visit the family and report back on the findings from the investigation, interview staff, write a report and share the outcomes with a serious incident panel. These aspects of my work role demonstrate my commitment to supporting people at some of their most challenging times.

I have built on the skills learned from undertaking my MSc study, and have spent the last five years developing my understanding and research proficiency. Also by using a mixed methods approach I have been able to gain a wide range of experience. Particularly over the past two years, as I have had carried out the research and used the different methods repeatedly I have gained greater levels of methodological competence.

I have had the privilege to present my findings at conferences, which has exposed my research to experts in the field. These provided me with the opportunity to receive feedback, to explain my work, to be challenged and to provide rationale and justification. At these events I also made links with others students, researchers' and experts who were interested in this research area: this was valuable for accountability, learning and in keeping a networking perspective.

The whole study took longer than I had originally anticipated, which at certain times caused some degree of personal stress. However, through discussion with my Academic Advisor and positive self-talk I chose not to rush the process. I knew that if I treated the research

journey as a sprint event I may overlook something, which could impact on the quality of the research.

I have demonstrated rigour by using valid research methods and providing clear methodology. For example when using thematic analysis, I was mindful of the need to be faithful to the data and systematic in my approach. It was also necessary to guard against selecting portions of the data to support an argument rather than describing the data set. Braun and Clark (2006) and Joffe (2012) highlight the need to have a balanced view of the data and its meaning, rather than focusing on frequency of codes from within the data set.

Further evidence of rigour within thematic analysis is the requirement to have a transparent trail of how the data was collected and analysed. Boyatzis (1998) states that because a data driven code is highly sensitive to the context of the raw information, one is more likely to obtain validity against criteria and construct variables. Within my use of thematic analysis all the themes and codes could be traced back to the participant through quotes within the survey or interview transcripts.

Whilst some of the thematic analysis literature promotes having codes and themes checked by a research assistant, others suggest that by eliminating intermediaries it can prevent possible contaminating factors. There were times during the months of analysis when I forgot a step that I had already taken and unnecessarily repeated it. Although on occasions there was a small variance where a code could be placed in more than one theme, on the whole the process of data analysis demonstrated accuracy.

A quality recommendation when using narrative analysis is to strive towards 'trustworthy interpretations of the data', rather than claiming truth. Riessman (1993) writes of persuasiveness being at its most potent when it is supported with evidence from authentic accounts. Riessman (2008) highlights two levels of narrative validity, one being the story of the research participant, and the other being the validity of the analysis- in other words the story of the researcher. Riessman (2008:186) goes onto to emphasise that "narrative truths are always partial – committed and incomplete". In all of the months of analysis of the narrative data, the participants' stories were at the heart of my research, as I endeavoured to work closely to Riessman's method and developing interpretations.

There were common themes across the participants' accounts and the accounts were in line with previous studies carried out by other researchers. Both the survey and interview data provided information- rich cases.

The survey and interview data provided by practitioners contained a variety of experiences of working with suicidal clients. Relying on retrospective recall of specific events may have meant that memory fluctuations could impact on validity. However, many of the participants refreshed their thinking by reviewing their completed surveys, process notes, case notes, supervision notes, journals, client suicide letters and coroners' reports: I believe that all of this added to the trustworthiness of participant's accounts.

With the recordings of the interviews I listened to the interview recordings numerous times and read, reread and discussed the transcripts with my research assistant. This meant that I was not relying on memory alone, and had the opportunity to check ideas and thoughts with my colleague.

Thorough data collection meant that I had a strong data set from both a numerical and content perspective. By using a mixed method approach, the data could be analysed in a layered and systematic manner. In addition by using more than one approach I demonstrated a preparedness to test, compare, contrast and analyse the data from multiple viewpoints.

4.8.3 Transparency and Coherence

I sought to have the research question at the forefront of my thinking, have been explicit about my method and methodology, and have endeavoured throughout the research to report on gaps and inconsistences.

I have kept a research journal since 2011 which has enabled me to recollect decision making, detours, methodological awareness, critical self-analysis, act as a memory prompt and allow for reflexivity. During the research journey my Academic Advisor, Academic Consultant, critical friends, peers, my signatory and experts in the field have helped me to stand back and be judicious with the research data. I continued to be held accountable for the appropriateness of the research, and products that I wanted to devise. The process of

reflectivity and discussion with colleagues also enabled me to consider any likely research bias, and to guard against contaminating the data.

Throughout the process of data collection, analysis and report writing I have made notes at each stage. In addition all of my findings can be traced back to either the interview transcripts, audio recordings and/or the survey questionnaire.

The survey and interview data has provided breadth and depth of insight from professionals working with suicidal clients. The examples selected demonstrate the struggles, challenges, strengths and weaknesses of the contexts in which they work, their training preparation, management and supervision support. Each of these aspects has contributed to the products that I have created during this research journey.

As an example, each component of the training programme I have devised originated from the contributions of practitioners' ideas of what they had valued from their training, and what they would like to have covered but did not have the opportunity. I have delivered this training to more than 300 professionals. At each session the training has been evaluated by participants and I have reviewed their feedback and responded to their comments. The feedback has been very encouraging, and demonstrated the appropriateness and fitness for purpose of the training material. This in turn gives me confidence that what started as a research project, has made the transition into a meaningful resource for professionals working with suicidal clients.

I am also confident that the collated narrative accounts also demonstrate persuasive and convincing accounts of working with suicidal clients, which when published will communicate powerfully to readers.

Throughout this journey I have sought to demonstrate reflectivity with regard to my personal motivations for undertaking this study, to consider the study's impact upon my own life and wellbeing, and to describe my hopes, fears, triumphs and failings in the research journey.

4.8.4 Impact and Importance

To complete a doctorate which only sits on a library shelf was never a motivating factor for me. However, to design or create something which improves, assists or makes a difference to the lives of others was something which I strongly desired.

From the current literature and my own research it was clear that practitioners felt unprepared for working with suicidal clients. I had also seen professional's lives dramatically affected following client suicide. In the role I held within the NHS I felt uniquely positioned to be able to make a difference. I wanted to use the findings of my research to create products which innovate professional practice through relevant training and support of staff.

Evaluation of the workshops I have conducted, has evidenced that participants have valued the teaching from a theoretical perspective, and this has given greater understanding and contributed to change in the way they think about the subject matter. Through role play and skills practice, participants have reported an increase in their ability levels and confidence to have difficult conversations with those who are suicidal.

Participants' feedback has also shaped the training with regard to the importance of some exercises over others, or time spent on certain activities. It has also highlighted the need to consider the demographic of the group, and whether they are trainees or qualified practitioners.

An unforeseen result of my research has been the development of self-care programmes within the NHS. I now present seminars on the need for self-care within stressful environments at induction days, and as part of suicide and risk training.

I have also been invited onto three steering groups for policy change within the NHS. These groups are the Towards Zero Suicide programme, the Risk Training group and the postvention support programme.

I have wanted this research project to demonstrate quality and validity throughout. My aim was for the participants to provide testimonial validity, as outlined by Stiles (1993), catalytic validity as highlighted by Lather (1986) and (1991), and participation orientation as

suggested by Potter and Wetherell (1987). Stiles (1993) also points to the importance of reflective validity, and as a researcher I have endeavoured to exhibit this in my work. As for readers or participants of my teaching or workshops I hope that my research will prove to be coherent, and display transferability as recommended by Morrow (2005). (See Appendix Z for diagram on adherence to validity).

4.9 Reflectivity

During 2015 I became completely overwhelmed by the amount of data which was generated from using a mixed methods approach; there were occasions when the task I had set myself caused me to feel as if I was drowning in data. I felt as if the research would never end, and although I would not say I became depressed I did feel low, stressed and trapped at times. This fed my own core beliefs of being a failure and impacted on my ability to think clearly. This in turn reminded me of my personal learning difficulties and made me doubt my ability to succeed. Discussions with my Academic Advisor, Academic Consultant and critical friends proved to be instrumental in keeping me focused and on track.

I also wanted to do justice to the practitioners who had taken the time to complete the survey and take part in interviews. People had shown such interest in my research, had given incredibly revealing answers and expressed great vulnerability. I felt a keen sense of responsibility in portraying their accounts and stories in a way which was congruent and respectful.

4.10 Summary

In this chapter I have outlined the processes I utilised in carrying out the research, and the systematic analysis of the quantitative and qualitative data using a mixed methods approach (large scale survey and individual interviews). In addition I have reflected on the ethical issues I faced (mainly related to sensitivity of context), and how I sought to demonstrate the importance of quality and validity in my work. I have also considered the impact and importance of this research in relation to developing greater support for practitioners (through training products).

In personally reflecting on the process of research I have recognised some personal impact and taken steps to adjust practically and emotionally. The task of carrying out this research was far greater than first imagined, as demonstrated in the forecasted timeline in my Learning Agreement. This was partly due to the volume of data generated from using a mixed methods approach (22,000 words from the survey and in excess of 115,000 from the interview transcripts) and also the fact that I wanted to consider the data in sufficient detail and not rush the process.

I found that the implementation of the survey was exciting, because participants showed interest in the research and a willingness to take part in the study. However, although I had thought that analysing the survey data would be straightforward (and then I would quickly move on to the second phase), I found it took much longer because there was constant interaction between the two phases as I moved from one to another, along with navigating between the narrative and thematic analysis.

The data was not just a set of information but individual people's stories: each person to varying degrees had experienced a significant incident with the suicide of a client, and even though it is unlikely I will ever meet them again I have been involved in their lives. When I speak about their stories at conferences or training events I want to present their experiences with integrity and respect.

Thus I have endeavoured to demonstrate sensitivity to the study, commitment and rigour, transparency and coherence, and create products that will have a lasting impact on client care and the support and training of practitioners.

In the next chapter I will outline the findings from phase one of my research.

Chapter Five: Phase One Findings

In this chapter, I will present the findings from analysis of the quantitative and qualitative data in phase one of the research study. The results for each question from the survey will be presented in chronological order.

Quantitative and Qualitative Data from the Survey

5.1 Practitioner Information

Question 1

Of the practitioners completing the survey, 18% were male and 82% were female. The BACP report their membership to be around 44,000 counselling professionals with 82% female and 18% male, and although the survey was sent to a wider professional population than counsellors and psychotherapists, the male/female ratio of the sample appears similarly proportionate and therefore reliably representative.

Question 2

Table 5: Results of Question 2

Table 5

Question 2: Professional Title

			Response Percent	Response Total
1	Counsellor		44.55%	49
2	Drugs and Alcohol Worker		0.91%	1
3	Mental Health Practitioner		6.36%	7
4	Nurse		7.27%	8
5	Psychiatrist		0.91%	1
6	Psychologist		6.36%	7

Table 5

Question 2: Professional Title

			Response Percent	Response Total
7	Psychotherapist		39.09%	43
8	Social Worker		1.82%	2
9	Other (please specify):		14.55%	16

Analysis								
	Mean:	6.945	Std. Deviation:	4.592	Satisfaction Rate:	57.27	answered	110
	Variance:	21.086	Std. Error:	0.438			skipped	0

Table 5 provides an overview of practitioners by their professional title. Under the category of 'other', participants identified their profession as clinical supervisor, counselling supervisor, cognitive behavioural therapist, assistant psychologist, team therapist, assistant psychologist, mental health nurse, specialist health visitor, support worker and social worker. A number of participants provided more than one professional title demonstrating dual roles or occupations. In particular, a significant proportion of participants identified themselves as both a counsellor and psychotherapist and thus ticked both categories.

5.2 Working with clients who express suicidal ideation

Question 3

All participants indicated that they had worked with clients who had expressed suicidal ideation at some point during their interaction.

Table 6 shows the settings in which professionals were working at the time that their clients' made a disclosure of suicidal ideation. The category of 'other' included schools, higher education, universities, Employee Assistance Programme (EAP), Occupational Health Service, Social Care, hospices, Complex Needs/ Specialist services, Acute Inpatients and probation services. The results highlighted that some participants had been working in more

than one setting. One person skipped answering this question but when interviewed confirmed this had not been intentional.

Question 4

Table 6: Results of Question 4

Table 6

Question 4: In what setting/s were you working?

			Response Percent	Response Total
1	Drug and Alcohol Service		6.42%	7
2	Private Practice		37.61%	41
3	Primary Care		22.02%	24
4	Secondary Care		33.94%	37
5	Social Work		1.83%	2
6	Voluntary Sector		26.61%	29
7	Other (please specify):		21.10%	23

Analysis								
	Mean:	6	Std. Deviation:	3.346	Satisfaction Rate:	75.08	answered	109
	Variance:	11.193	Std. Error:	0.32			skipped	1

5.3 Working with clients who have attempted suicide

Question 5

When asked whether they had worked with clients who have attempted to take their life by suicide 85% responded that they had, and 15% responded that they had not.

Question 6

In question 6 participants were asked to comment on their experience of working with clients who had attempted to take their life by suicide, and to indicate any challenges that this had caused. I used thematic analysis as described in the previous chapter to analyse the participants' responses, and the three themes which emerged were professional responsibility, inner conflict and practitioner vulnerability. Figure 3 shows the thematic map for this question and initial thematic content can be found in Appendix J.

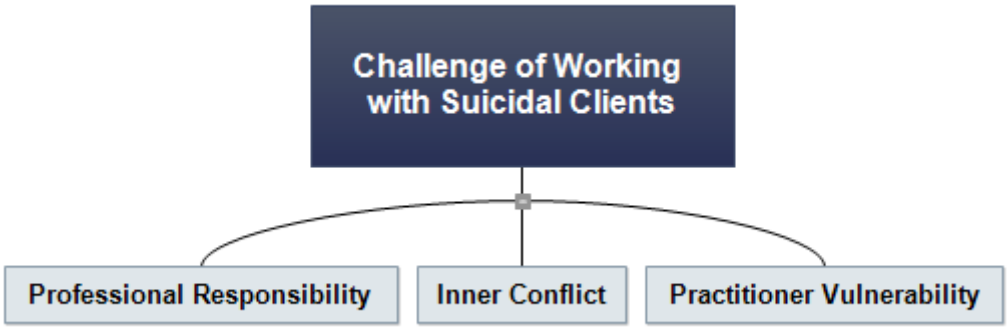

Figure 3: Thematic Map for Question 6: Challenges Faced by Practitioners

- Responses related to **professional responsibility** highlighted what it means to be a practitioner in a demanding role, and at a particularly difficult time. This theme included the principle of maintaining professional relationships, not just in the therapeutic relationship, but also with colleagues, other clients, and the organisation worked for. There was a need to maintain the boundaries of such relationships even when the client is on the very edge of life, and the practitioner was still required to stay within that fragility. There was a need to hear graphic and difficult content, to encourage open and honest conversations and to know when to keep or to break confidentiality.

  "The Main challenge was with clients who continued to make attempts in many different ways and yet failed to take their life- they feel a sense of failure and underachievement- for me I found it difficult to support them during repeated serious attempts, and this affected our therapeutic relationship, as sessions would be

missed/cancelled because they were receiving physical treatment for the latest attempt before continuing sessions with myself". (Participant 8)

- **Inner conflict** seemed to be the tensions positioned between the professional self and the practitioner as a vulnerable human being. Inner conflict incorporated elements of dilemma, difference, difficulty and decision making. Whilst a lot of professions have areas of challenge, the sense of a practitioner being personally conflicted seemed to be present. This was acutely felt in the area of confidentiality, and knowing if and when to move from discussion about the desire to take one's life and forming a risk management strategy, or to refer the client on. Inner conflict was also keenly felt when the client and the practitioner had opposing views on the topic.

  "Sometimes the need to honour an organisational commitment to client safety, can mean that clients may be deemed unsuitable for counselling if they are actively suicidal". (Participant 38)

  "Always difficult to assess risk, and whether the client will benefit from the counselling. A decision has to be made between confidentiality and safety and the need to disclose". (Participant 59)

- **Practitioner vulnerability** represented deeply personal aspects of the work which demonstrate their own anxiety, fears, need to make the right decisions and possible activation of negative core beliefs. At the centre of the professional persona is the ordinary person, who may struggle with everyday issues of life and death. Each professional, having a history which has shaped them into the person they are today, may have had their own mental health issues, or have responsibility for family members who have been mentally or physically unwell. They may also be experiencing employment or financial concerns. Any such issues are going on in their personal background whilst they are working with their clients. It would seem that when clients go into crisis, the practitioner's own vulnerabilities can rise to the surface- perhaps appearing in the form of a strong desire to rescue the client/ keep them safe or to keep the practitioner's own sense of fragility from being exposed.

"I have had experience of suicide in my family, and the first suicidal client I worked with after this event was terrifying. I was only too aware of the impact it could have on me if this client committed suicide, and I was probably more reactive than responsive. It affected my sleep, eating and took up a lot of my head space. Fortunately I had an amazing supervisor who held me at this time, and it actually had a positive long term effect". (Participant 22)

Question 7

This question invited participants to consider their thoughts and emotions at the time of their client's suicide attempt. Figure 4 shows the thematic map for this question, and the initial thematic content can be found in Appendix K.

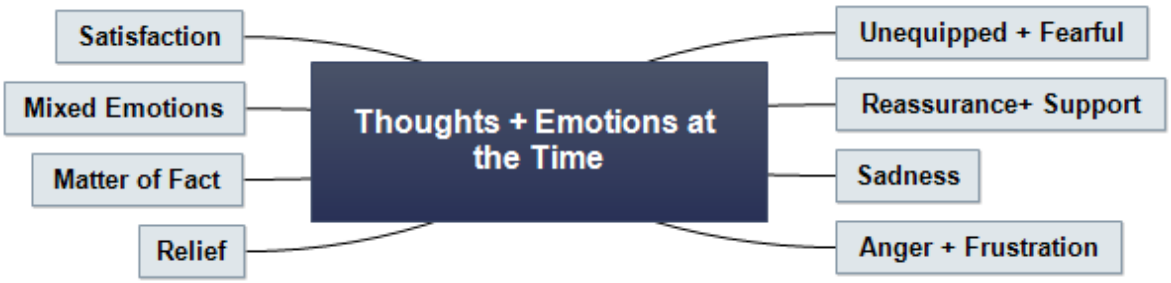

Figure 4: Thematic Map for Question 7: Thoughts and Emotions Following Suicide Attempt(s)

The themes in this section produced a wealth of diverse thinking and emotions.

- **Relief** was expressed in relation to hearing that help had arrived in the form of paramedics or health professionals. Some participants wrote of the relief which they experienced when they heard that their client had survived, whilst others wrote of the relief that they experienced in being part of a team, and so having a shared responsibility. Overall there seemed to be expressed a strong need for the client to be saved from death at their own hands.

  "I felt relief that they didn't succeed in the attempt". (Participant 73)

- However, a more '**matter of fact'** stance was evident in a small proportion of responses. This theme encompassed the view point of not taking the suicide attempt personally, which could have meant maintaining distance or a defence mechanism, or else allowing autonomy for the clients' choice. Other responses indicated their own lack of fear in relation to death, which they felt gave them the ability to accept and tolerate a client speaking about their wish to die.

  "It is part and parcel of what we do. I do my best to empathise with the client at all times. It is not personal to me". (Participant 27)

- **Mixed emotions** represented the whole spectrum of human feelings; for some this meant recognising in one moment that they felt hopeless, and a moment later feeling hopeful. For others, it was anger followed by guilt, and for others a feeling of calm followed later by a sense of dissociation. There seemed to be elements of contradiction or emotional extremes demonstrating the complexity of emotions and the antecedents of thinking which can change human feelings in an instant.

  "Thankfully, I have not had a client act on their thoughts whilst working with me. I have had clients, who have threatened to. Some of my emotions have surprised me. I expected to feel anxious, concerned etc... But I have been surprised that sometimes I also feel angry or exasperated towards them. This has been difficult for me as it's accompanied by feelings of guilt". (Participant 101)

- **Satisfaction** included an appreciation of the work done with the client despite the challenges, whilst others wrote of the privilege that their clients had been able to share their deep and private thoughts.

  "I would also experience hope, happiness, and satisfaction - especially when I worked successfully with young people to build the life they wanted to live in". (Participant 69)

- **Reassurance and self-support** included both positive and negative aspects; supportive aspects included practitioner positive self-talk and encouragement from their supervisor, colleagues and family. Negative aspects came in the form of feeling

isolated and withdrawn from support systems; some participants expressed a lack of support from their professional bodies. Although there was a perception of authority and power with regard to their professional bodies, when the practitioner needed advice or support they were left feeling on their own.

"Fears about how I had dealt with the client, little support from professional agencies (BACP mainly). It was a relief for it eventually to be called an accident, but his actions with a loaded gun did indicate a lack of care for his safety". (Participant 80)

- **Anger and frustration** appeared to be focused in a number of directions. Practitioners expressed an inner anger towards themselves, that perhaps they should have done more to prevent the suicide attempt. There was also anger directed towards the client for their actions, or for some the anger was on the clients' behalf for the lack of support, care and understanding from their families. Participants also expressed degrees of frustration and anger towards other health professionals, professional bodies and organisations. For some it was as if the client was the 'hot potato' which no one wanted to handle. This may reflect the tension within health care as to levels of suicidal risk, duty of care and referral pathways.

  "The attempts were usually reported to me after the event. The main feelings were of disappointment and frustration. The client did have potential to make life okay for herself and her son but somehow could never quite break out of an enclosed self-loathing and hopelessness". (Participant 98)

- **Sadness** was directed at the practitioners' own sense of loss or rejection, along with sadness for the clients' miserable life or difficult family circumstances. Within this theme, the weight and burden of this type of work was expressed, which can be reflected in transference and countertransference. It would appear that the affliction of human suffering in clients can leave a mark upon the practitioner which is not easy to bear.

  "Through use of my embodied empathy, I have had to -and still have to be- aware that I can be left with a heaviness/sadness residue from the client. It obviously is heavy work, as sometimes people's lives are rubbish". (Participant 100)

- **Unequipped and fearful** seemed to result from a sense of being out of one's depth, or of being the first on the scene and finding a patient who had made a serious suicide attempt, thus feeling helpless and questioning one's ability to help. This may be related to a training need, or it could represent how the gravity of the incident would be traumatic for anyone in that situation. Concern was also raised in relation to the possible repercussions on the practitioner if their client died.

  "Frequent wonderings about the client - whether they were still alive. One particular client who was actively suicidal on a daily basis lived near to myself and it was tempting to notice lights, or bicycles etc. when driving past her residence. Although I found it generally easy to remain psychologically boundaried, there were times when thoughts seeped through and intruded my leisure time" (Participant 88)

  "Feeling completely unequipped to help someone, you listen and just feel a bit useless not knowing what to say to help. This can almost make you dread being asked for 1:1 time. It is emotionally draining. Finding patients with ligatures around their neck was difficult and distressing". (Participant 92)

Question 8

This question invited participants to consider whether they had made any adjustments to their schedule or the way they worked in the light of their clients' suicide attempt. 64% of participants reported making adjustments whilst 36% reported that they did not.

Question 9

Participants were then asked to provide details of the adjustments that they made. There were five thematic themes which were apparent for this question -self-support, support of others, contact with other professionals, additional contact with the client and having additional duties. Figure 5 shows the thematic map outlining adjustments made following a client suicide attempt.

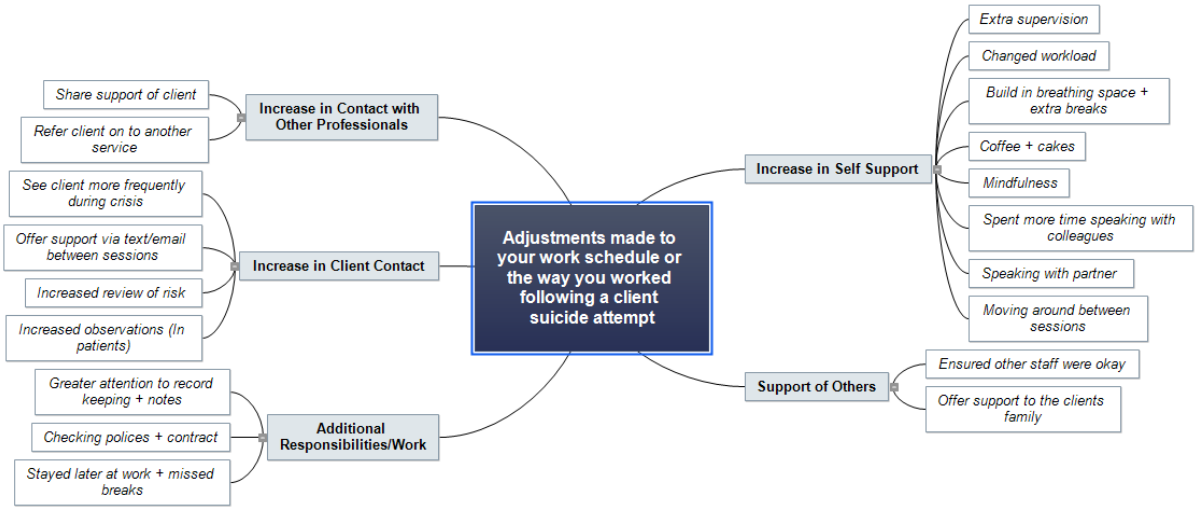

Figure 5: Thematic Map for Question 9: Work Adjustments Following Client Suicide Attempt

What appeared to be present in this section was a marked increase in activity following a client suicide attempt. Whilst some of the increase was around taking steps to monitor and protect personal wellbeing, some participants indicated a need to protect the client, in the form of additional client sessions, texting between other sessions, or carrying out observations within inpatient settings. Additional duties revealed such activities as reading policies and procedures, checking client contracts, writing more extensive client records, or checking and changing client records. In order to undertake such tasks, practitioners commented that they had missed breaks or left work late.

> *"Increased the number of sessions to twice weekly to provide more containment". (Participant 77)*

> *"Stayed later to make GP and crisis appointments for someone. Took more time completing medical notes / process notes / carefully documenting decisions and actions. Prioritising seeing them over other clients who were not a risk to themselves. Taking more time in supervision to discuss suicidal clients. Asking my supervisor to provide a point of contact whilst I was away (which I wouldn't do for someone who was not at risk)". (Participant 84)*

Question 10

The last question in this section asked participants whether they had experienced a client taking their life by suicide: 31% of practitioners reported that they had experienced client suicide and 69% had not. If they answered no to this question skip logic took the participant to question 18 on the survey.

5.4 Working with clients who have taken their life by suicide

Question 11

The questions in this section were directed at those practitioners whose clients had died from suicide. Table 7 shows how long it had been since the practitioner's client had taken their life, and some participants had experienced more than one client death.

Table 7: Results of Question 11

Table 7

Question 11: How long ago did your client take their life?

		Response Percent	Response Total
1	Less than a year	11.76%	4
2	1 -2 years	32.35%	11
3	3-5 years	14.71%	5
4	6-10 years	35.29%	12
5	More than 11 years	11.76%	4

Analysis							answered	34
	Mean:	3.206	Std. Deviation:	1.285	Satisfaction Rate:	53.68		
	Variance:	1.65	Std. Error:	0.22				

Table 8: Results of Question 12

Question 12

Table 8

Question 12: In what setting were you working?

		Response Percent	Response Total
1	Drug and Alcohol Service	11.76%	4
2	Private Practice	11.76%	4
3	Primary Care	5.88%	2
4	Secondary Care	47.06%	16
5	Social Work	0.00%	0
6	Voluntary Sector	5.88%	2
7	Other (please specify):	26.47%	9
Analysis	Mean: 4.618 Std. Deviation: 2.072 Satisfaction Rate: 58.82	answered	34
	Variance: 4.294 Std. Error: 0.355		

The category of 'other' included practitioners working in a school, hospice, acute in patient ward, Relate, an eating disorder service and Child and Adolescent Mental Health Service (CAMHS).

Question 13

When asked whether they were a trainee or a qualified practitioner at the time, 24% reported being in training and 76% reported being qualified.

Question 14

In question 14 participants were asked what thoughts and feelings they identified when they first heard that their client had killed themselves. Figure 6 shows the Thematic Map for question 14.

Figure 6: Thematic Map for Question 14: Thoughts and Feelings Following Client Suicide

There were 8 themes in this section -anger, sadness, fear, self-blame, disappointment, shock, acceptance and concern for others. Anger, sadness and fear had also been themes for participants who had experienced clients make a suicide attempt (see Figure 4). Table 9 gives an overview of the themes:

Table 9: Thematic Analysis of Question 14

Code Label	Theme Definition	Examples
Anger towards client, others, organisation	Anger	*"I was a bit angry as well as shocked - this seemed very manipulative".* *"Anger towards her mother".*
Sad Powerless Lowered mood Hopelessness	Sadness	"*Complete and utter sadness that the client had felt so alone".*
Anxious Frightened Concern Fear	Fear	*"Will the family complain?"* *"Will there be an investigation?"*
Guilt Shame	Self-blame	*"I felt it was my fault".* *"Did I do enough?"*
Regret Waste	Disappointment	*"It seemed like a waste of a life ".*

Numb Shocked Disbelief Horror	Shock	*"OMG"* *"I was shocked at the suicide method".* *"I was present at the time due to it being an inpatient unit and I found the person".*
Resignation, Relief Peace	Acceptance	*"She had made it clear over several years that this was her intention and it was just a matter of when not if."* *"Accepting that the client will no longer go through the pain they are going through".*
Staff Family	Concern for others	*"Concern for his wife and 4 children and for his CPN".*

The initial thematic content for question 14 can be found in Appendix L.

Question 15

When participants were asked in question 15 whether they had made any adjustments to their schedule or the way in which they worked following the death of their client, 44% responded yes and 58% responded no.

Question 16

This question invited participants to comment on the adjustments they had made to their work schedule, or the way in which they worked following their clients suicide. Appendix E, EE, F and FF outline stages 1 - 4 of the thematic process and the themes are represented in Figure 7:

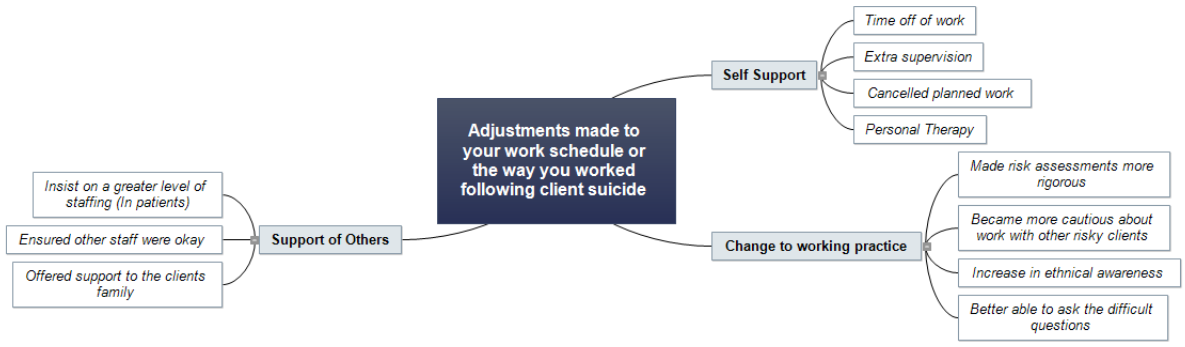

Figure 7: Thematic Map for Question 16: Work Adjustments Following Client Suicide

The development of stage 4 showing codes, themes, descriptions and example quotes from the survey is outlined in Table 10:

Table 10: Thematic Analysis of Question 16

Did you make any adjustments to your work schedule or the way you worked?

Code Label	Theme Definition	Examples
Time off	Self-support	*"Granted me two weeks off".* *"I needed to take time out".*
Extra supervision	Self-support	"*I felt particularly concerned that I should get extra supervision".* "Changed from group to individual supervision".
Personal therapy	Self-support	"*I also returned to therapy as this brought up issues from my past".*
Risk assessments	Changed working practice	"*I made my risk assessments more rigorous".*
Review of work	Changed working practice	*"Reviewed what I do with clients who I feel may be at risk".*

	Self-support	*"I cancelled planned work".* *"Declined taking on new clients".* *"I asked not to be allocated complex cases and any clients with known suicidal ideation until I felt ready".*
Cautious	Changed working practice	*"Became more cautious about work with other risky clients".* *"More crisis management and hospitalisation".* *"Risk averse- not willing to take on risk".* *"Possibly seeing more risk following client suicide".* *"Not willing to take risks and wanting to take easier option of admission to hospital".*
Equipped	Changed working practice	*"I felt better able to ask the difficult questions".* *"I became more ethnically aware".*
Crisis management	Changed working practice	*"Risk assessment checked this out at each group".* *"Possibly seeing more risk following client suicide".*
Reporting	Changed working practice	*"Informed all those who needed to know".*
Recording	Changed working practice	*"Completed the notes/incident form".*
Observations	Support of others Changed working practice	*"Regardless of staffing levels I had to increase several patients' levels of observation".*

Staffing	Changed working practice Support of others	*"Insisted that a greater level of staffing be made available".* *"I ensured other staff were okay".*
Family	Support of others	*"Offered support to the family".*

Once satisfied that stage 4 was complete I formulated a thematic map. Braun and Clark (2006) imply that at Level 2 the thematic map should accurately reflect the overall meaning of the data set as a whole.

Stage 5 involves defining and naming the themes; it requires writing a detailed analysis for each theme, along with the 'story' that the theme is telling. At this point sub themes or themes within a theme may become apparent. Braun and Clark (2006:92) suggest that these can provide a 'structure to a particularly large and complex theme'.

In question 16 of the survey participants were asked what adjustments they had made to their work schedule following client suicide. The following themes emerged from the data:

- **Self-support** encompassed actions taken by participants' to protect themselves at a time of significant challenge. These actions involved taking time away from work in order to recover, making changes to their caseload and seeking additional personal and professional support. Some participants experienced being unable to sleep, becoming tearful with issues from their past coming to the surface. The support they sought took the form of changing or gaining supplementary supervision, or seeking personal therapy. These forms of self-care seem critical in order for practitioners to be able to work through their thoughts and feelings in relation to the death of their client, and to have the resources to continue to work with other clients. Seeking support in this way demonstrates practitioners' honesty, professionalism, awareness of their limitations and ethical responsibility.

"As I was a trainee with little experience, I felt particularly concerned that I should get extra supervision. I also returned to therapy as this brought up issues from my past". (Participant 29)

- **Support of others** covered the care of staff, clients' and the family of the dead client. For some practitioners, not only did they have to deal with their own personal issues in relation to the death of the client, but also those of other staff members. When a client takes their own life there can be a significant impact on the wider team. For managers, supervisors and colleagues the care of the team is essential for their ongoing wellbeing, and the maintenance of strong team dynamics. Client suicide can cause debilitating anxiety, which if not addressed can contribute to stress, trauma and burnout within the team. In addition, the continued care of other clients is paramount- whether the practitioner is a nurse on a ward or a psychotherapist.

Within some NHS Trusts it is mandatory to contact the client's next of kin to offer condolences, check their wellbeing and to explain the investigation process. Whilst this process is good practice, it can be very challenging for the practitioner involved, who on occasions may have to take the full brunt of the family's anger; having good support in place is extremely helpful at times such as these.

"Regardless of staffing levels I had to increase several patients' levels of observation and insist with senior management for more staffing to be made available". (Participant 72)

- **Changed working practices** covered a wide array of variations to clinical practice and included both increases and decreases in clinical work. For some practitioners, in addition to their normal work load, they had to carry out procedures in line with organisational policies following client death. This can be a stressful time ensuring that reports and note keeping is up to date. There is also the added concern about the investigation process, such as being interviewed, speaking with solicitors, facing the client's family or attending the Coroners court.

Some practitioners had considerable concerns with regard to risk levels, and this meant either adjusting their caseload to take on less risky clients, or making their risk assessments

more robust in order to safeguard against further client suicide. Clearly, crisis management and escalating suicidal clients to hospital was imperative for some practitioners, rather than holding on to the higher levels of risk.

Within this theme, some practitioners highlighted that they had experienced a period of reflection, leading to greater understanding and a renewed confidence in their work.

> *"Reviewed what I do with clients who I feel may be at risk, with literature from a course and with my Supervisor and made my risk assessment more rigorous. For example, I felt better able to ask the difficult questions". (Participant 33)*

Silverman (2000) indicates that quantitative research can amount to a 'quick fix', involving little or no contact with people. However I found that although I did not have direct contact with the survey participants, I was not fully prepared for the depth and honesty with which practitioners shared their responses. Upon consideration, perhaps their openness was due to the fact that many knew they would never meet me.

Question 17

In question 17 participants' were asked for their current thoughts and feelings about their client's death, and its impact upon them now. Three themes arose from the analysis indicating that they were still marked by the experience- regret and questioning, sadness and acceptance. These themes seemed to formulate into a continuum, as shown in Figure 8:

Figure 8: Thematic Map for Question 17

- **Still marked by the experience** - I wondered with this theme only depicted practitioners' thoughts that had more recently experienced client suicide; however, it appeared that this was not the case, because some practitioners clearly continued to feel impacted by the event many years later. Comments such as "You don't forget", "It has had a lasting impact", and ''I have a very incomplete picture which will never change" were prominent, along with "Thinking about it produces a feeling of horror" and "It creates anxiety and apprehension when I encounter similar patients".
- **Regret and questioning** encompassed thoughts about why the client had not been able to work through their pain, or that the suicide might have been avoided. Statements were expressed such as "I often think about it and wonder if there would have been another option", "I still have many unanswered questions" and "I have regrets about the work".
- In the theme of **sadness and acceptance** practitioners portrayed a knowledge that they did the best they could possibly do for their client. Statements were expressed such as "I hold in my awareness that for some people they cannot find a way through their difficulties. It is very sad, but I have to accept that" and "Sadness -but a sense of them being at peace and no longer feeling tortured".

Initial thematic content for this question can be found in Appendix M.

5.5 Support Network

The aim of the questions in this section of the survey questionnaire was to ascertain the level of support that practitioners received whilst working with their suicidal clients.

Question 18

Question 18 enquired as to practitioners' perceived support from their managers. As some counsellors and psychotherapists worked in private practice this question was not relevant to all practitioners. When I designed the survey I graded the spectrum of support between 0 = not at all and 10 = excellent. However, in hindsight this made calculating the level of support very difficult as it was too non - specific, and I had to return to a cross section of practitioners and ask them to grade which numbers between 0 and 10 equated to

poor/unsatisfactory, average /satisfactory and good to excellent. The practitioners rated 0-4 as being poor/unsatisfactory, 5-7 as average/satisfactory and 7+ as good to excellent.

The data in Table 11 highlights that of the 90 practitioners who had a manager at the time of their work with suicidal clients, 18% (*n*=17) of practitioners rated the support they had received as poor or unsatisfactory, 16% (*n*=14) suggested that support from management was average or satisfactory, and 66% (*n*=59) indicated that it was good to excellent.

Table 11: Results of Question 18

Table 11

Question 18: If you had a manager how supported did you feel if 0 = not at all and 10 = completely?

	0	1	2	3	4	5	6	7	8	9	10	Response Total
Supported	1.1% (1)	4.4% (4)	4.4% (4)	1.1% (1)	7.8% (7)	6.7% (6)	8.9% (8)	6.7% (6)	17.8% (16)	18.9% (17)	22.2% (20)	90
											answered	90
											skipped	20

		Percent	Total
1	0	1.11%	1
2	1	4.44%	4
3	2	4.44%	4
4	3	1.11%	1
5	4	7.78%	7
6	5	6.67%	6
7	6	8.89%	8
8	7	6.67%	6
9	8	17.78%	16
10	9	18.89%	17
11	10	22.22%	20

Analysis							
	Mean:	8.156	Std. Deviation:	2.72	Satisfaction Rate:	71.56	answered 90
	Variance:	7.398	Std. Error:	0.287			

Question 19

The same principle as above was applied to question 19 with practitioners being invited to rate the level of support that they had received from their supervisor. Table 12 highlights the findings from question 19 showing that 4% (*n*=4) of practitioners rated the supervision they received during the time they were working with suicidal clients as poor or unsatisfactory, 7% (*n*=7) suggested supervision was average or satisfactory and 89% (*n*=95) indicated that it was good to excellent.

Table 12: Results of Question 19

Table 12

Question 19: If you had a supervisor how supported did you feel if 0 = not at all and 10 = completely?

	0	1	2	3	4	5	6	7	8	9	10	Response Total
Supported	0.9% (1)	0.0% (0)	1.9% (2)	0.9% (1)	1.9% (2)	4.7% (5)	6.6% (7)	4.7% (5)	15.1% (16)	21.7% (23)	41.5% (44)	106
											answered	106
											skipped	4

Supported by Supervisor		Percent	Total
1	0	0.94%	1
2	1	0.00%	0
3	2	1.89%	2
4	3	0.94%	1
5	4	1.89%	2
6	5	4.72%	5
7	6	6.60%	7
8	7	4.72%	5
9	8	15.09%	16
10	9	21.70%	23
11	10	41.51%	44

Analysis							
	Mean:	9.415	Std. Deviation:	2.064	Satisfaction Rate:	84.15	answered 106
	Variance:	4.262	Std. Error:	0.201			

Question 20

This question asked participants whether there were any additional steps they took to support or care for themselves whilst working with a suicidal client, or following the death of their client. 76% (*n* = 83) provided comments, 19% (*n* = 21) stated that no actions of self-care were implemented, with some stating that there was not the time available due to work pressures, and 5% (*n* = 6) skipped the question. The themes from this question demonstrated that practitioners sought additional support from other professionals, family and friends, undertook care of self at work and/or care of self at home.

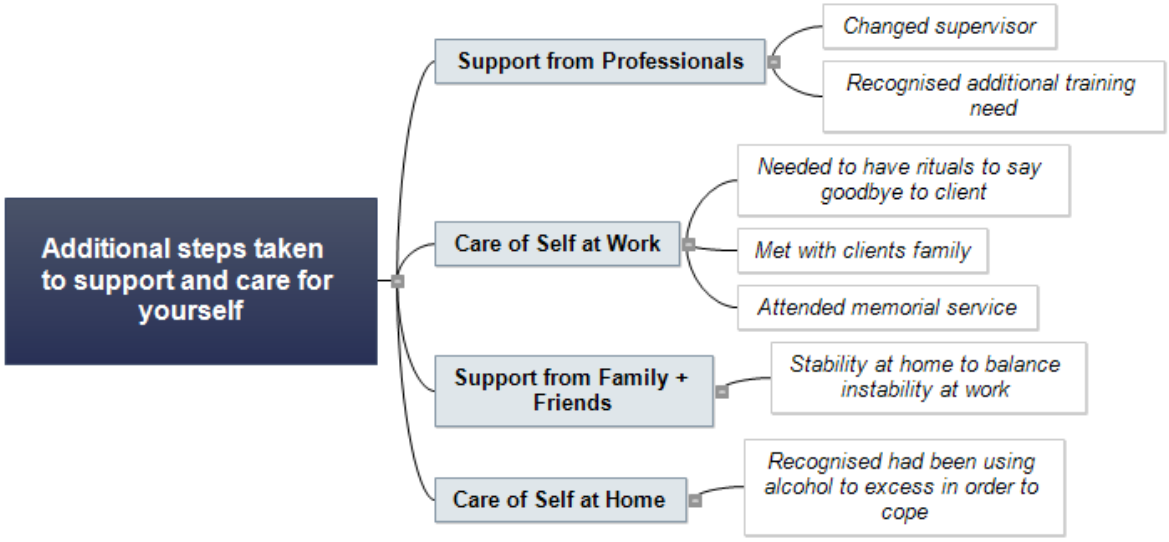

Figure 9: Thematic Map for Question 20: Personal Care and Support

- **Support from professionals** included time spent with supervisors. Practitioners needed to discuss the implications of their suicidal client, devise techniques, consider boundaries and process issues, along with transference and countertransference concerns. One participant mentioned changing supervisors due to feeling unsupported and let down. Line managers and colleagues were approached for support in decision making, to offload, seek reassurance, debriefing and for reflection. Other participants returned to personal counselling in order to reflect on material triggered by their work, such as revisiting experiences of family

suicide or transference and countertransference issues. Collaboration and discussion with GP's was another area that practitioners accessed to gain support.

"Line Management was the most effective supporting factor. De-briefing, reflection. Peer support is vital. Scheduled supervision was important for personal reflection". (Participant 24)

- **Care of self at work** demonstrated the need for practitioners not to take on additional commitments, or giving themselves extra time at work for tasks. Participants also expressed the need to care of themselves by making space in their working day to reflect or just 'be', and taking regular breaks for food and time out.

  "Gave myself extra time and not rush around after difficult meetings, spoke to other colleagues about how I was feeling, sharing with my team any risky clients at team meetings, make sure I ate and drank in an appropriate manner - i.e. not missing meals, treating myself kindly , reminding myself that people make their own choices and praying".(Participant 67)

- **Care of self at home** was described by participants as the need for a clear boundary of mentally leaving the client at work in order to care for themselves as professionals. Care within their personal life included time spent enjoying exercise with hobbies such as walking, keeping fit, yoga and running. Self-soothing, massage and relaxation were all deemed to be useful, along with the need to have specific things to look forward to like weekends away. Spiritual discipline such as praying, meditation and mindfulness were also seen as supportive.

  "To do more self-soothing things for myself- having a relaxing bath, going for a walk to take time to process anything that I may be trying to block. I wanted to look after myself and work with it as best as possible". (Participant 41)

However although many participants mentioned self-care or self-soothing techniques, other practitioners referred to an increase in the consumption of alcohol to aid their ability to cope and mask their feelings.

Support from family and friends played a strong factor in gaining reassurance, care, support, physical contact such as hugs and having time to socialise. When work pressures prevailed, there seemed a critical need to have a strong sense of stability at home.

> *"Let my partner and close friends know what had happened (obviously not the details or the identity of the client) so they could understand if I felt the need for support or space". (Participant 109)*

5.6 Preparation for Working with Suicidal Clients

Question 21

The aim of this section of the survey was to establish whether the training that practitioners had undertaken, had prepared them sufficiently to work with suicidal clients. The results in table 13 show that 27% (*n*=30) of practitioners rated training they had received to prepare them to work with suicidal clients as poor or unsatisfactory, 24% (*n*=26) suggested their training was average or satisfactory and 49% (*n*=54) deemed the training as good to excellent.

Table 13: Results of Question 21

Table 13

Question 21: How adequate was your training in preparing you to work with suicidal clients if 0 = not at all and 10 = completely?

	0	1	2	3	4	5	6	7	8	9	10	Response Total
Prepared	2.7% (3)	0.0% (0)	5.5% (6)	12.7% (14)	6.4% (7)	10.9% (12)	12.7% (14)	16.4% (18)	17.3% (19)	9.1% (10)	6.4% (7)	110
											answered	110
											skipped	0

How adequate was your training in preparing you to work with suicidal clients?		Percent	Total
1	0	2.73%	3
2	1	0.00%	0
3	2	5.45%	6
4	3	12.73%	14
5	4	6.36%	7
6	5	10.91%	12
7	6	12.73%	14
8	7	16.36%	18
9	8	17.27%	19
10	9	9.09%	10
11	10	6.36%	7

Analysis							
	Mean:	7.036	Std. Deviation:	2.46	Satisfaction Rate:	60.36	answered 110
	Variance:	6.053	Std. Error:	0.235			

Question 22 and 23

Participants were asked to list specialist training they had completed in the area of working with suicidal clients, and specific areas of training which they would have liked to have covered, in order to prepare them for working with suicidal clients. These questions were not analysed using thematic analysis but are listed below in Table 14 and 15 and will be discussed in chapters eight and nine.

Table 14: Results of Question 22

Table 14 **Question 22 Specialist training you have completed in the area of working with suicidal clients**
• One day workshop on young people and suicide • Christine Padesky: 'CBT for depressed and suicidal clients' • Samaritans • Assist • CPD on self-harm and suicidal ideation • Local Survivors of Suicide group • DBT • Balint group • Self-harm • Risk assessment and management • Cruse Bereavement Care • Social work training • One day training provided by Social Care • Trauma training • One day training provided Bereavement Association • Psychiatric nurse training • Mental health training

- Counselling/psychotherapy training
- Suicidal clients 2 day training at Reading University
- Dr. Rachel Freeth outlining the medical and 'other' ways of working with suicidal clients
- One day of training on suicide
- Two day training on suicide
- 'Working with suicidal clients' presented by Mike Worrell & Linda Smith
- One day training by The James Wentworth-Stanley Memorial Fund run by Antonia Murphy of Counsellors and Psychotherapists in Primary Care
- Training for help line work for those with immediate need of support
- Agency policy during induction
- RATE
- Mentalisation for people with Personality Disorders

Table 15: Results of Question 23

Table 15 **Question 23: What specific areas of training would you liked to have covered to help prepare you for your work with suicidal clients?**
• How to respond to clients who express suicidal ideation and manage the session • Identifying intent • Historical indications • Statistics • Communication styles with suicidal clients • Interface with other professionals • Having assertive conversations in order to refer on • Network of support and referral pathways • Policies and procedures • Risk assessment and management

- Implications of risk in private practice/isolation
- Escalation factors
- Safeguarding factors
- Ethical issues
- Legal issues
- Mental Health Act
- Managing boundaries
- Contracting
- Depression and suicide
- Responding to myths about suicide
- Relationship between self-harm and suicide
- Philosophical viewpoint
- How to manage personal feelings about working with this client group
- Identifying the process of what is taking place between client and practitioner
- Samaritans/Assist
- Handling telephone calls with clients at risk
- Working with feelings of hopelessness
- Practical skills such as helping a client to prepare a toolkit of hope
- How to discuss with suicidal clients in a group setting
- Case studies
- Role play
- Bereavement skills to support clients who have experienced suicide of family members
- How to support staff after client suicide
- Practitioners training on how to cope following client suicide
- Self-support
- Initial practitioner training then refreshers
- Best training is experience and then reflection

81 participants provided comments on training they had valued in relation to working with suicidal clients, and 76 stated training they would like to have received in preparation for their work.

Whilst most participants only listed their comments on training, some individuals did make additional observations; the content of these indicated the epistemological and philosophical view point of the practitioner. A number of participants expressed that while they did receive training on how to work with suicidal clients, the theory did not adequately prepare them for the emotional experience of the work.

> *"I think the training I undertook was sufficient. Though I'm not sure anything ever prepares you for an 11 year old saying they don't want to exist anymore. I think it's more about having the experience and working your way through it with the young person". (Participant 7)*

> *"The interface with and implications for our private practice and our personal lives. There will have been a huge crossing of boundaries (suicide is not neatly arranged within working hours or within a convenient time frame) which affects us, our families and friends, and other clients quite deeply". (Participant 78)*

Participants proposed that core professional training needed to include modules on working with suicidal clients, followed by refresher training on a regular basis.

> *"I believe training needs to be put in place for anyone working with suicide as there appears in some courses to be a lack of it". (Participant 35)*

> *"I feel that CPD should include suicide ideation every couple of years as in my experience, people/counsellors are afraid to talk about the concept, it is more prevalent than the general public realise and with the misperception that talking about it may encourage someone to do it". (Participant 100)*

It was acknowledged that professional bodies and organisations needed to lead on disseminating research findings and best practice to aid practitioners. Suggestions were

made to include experiential learning, and although role play made some people feel uncomfortable or nervous, participants recognised its value for this type of work.

Question 24

This question invited practitioners to consider whether they had been changed in any way by their work with suicidal clients. Table 16 highlights that 71% of practitioners believed they had been changed by their work and 29% believed that they had not.

Table 16: Results of Question 24

Table 16

Question 24 Has your work with suicidal clients changed you in any way?

		Response Percent	Response Total
1	Yes	71.43%	75
2	No	29.52%	31

Analysis							answered	105
	Mean:	1.305	Std. Deviation:	0.457	Satisfaction Rate:	29.52		
	Variance:	0.209	Std. Error:	0.045			skipped	5

Question 25

Participants were asked to describe how they had been changed by their experiences of working with suicidal clients. Four themes arose and these can be seen in the thematic map in figure 10.

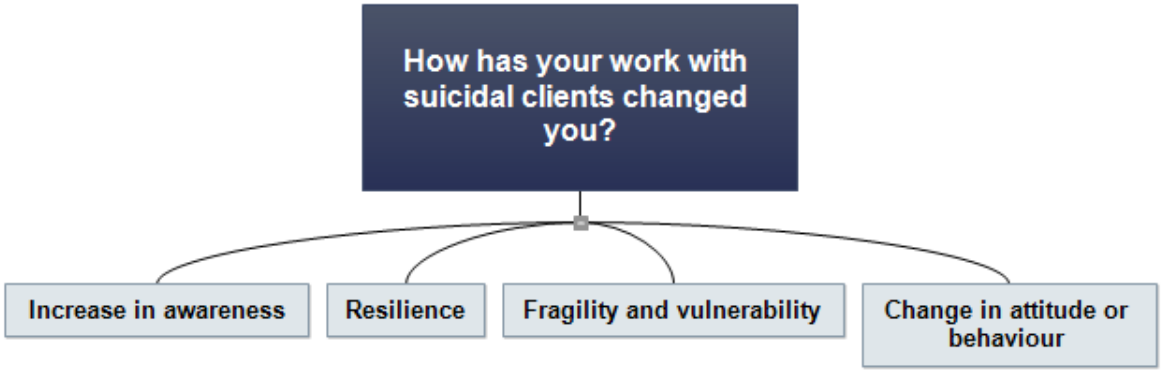

Figure 10: Thematic Map for Question 25: Personal Changes

- An **increase in awareness** showed how practitioners had developed as professionals. They recognised that they had gained a greater sense of knowledge and understanding which enabled them to approach difficult conversations more confidently, and to demonstrate advanced empathy. There was also recognition of personal limitations- for example one practitioner stated "It helped me to realise that I'm not a saviour - some things you just can't change in a person no matter how hard you fight for their life. They have to decide to live".

- The theme of **resilience** revealed acknowledgments of bravery, boldness, ability to cope and to be less frightened. One participant explained her thinking as follows, "In a similar way to personal life-changing events, the realisation that the worst thing can happen work wise and I can survive it, albeit changed by it".

  "I don't feel as frightened of working with suicidal clients as I initially did. I feel more able to cope with it through experience of it". (Participant 15)

  "I think I have understood myself to be more resilient, open to a client's experience rather than merely risk managing. I am also aware of the potential of a client to manipulate collusion and have heightened awareness of considering what is happening in the process". (Participant 18)

- **Fragility and vulnerability** revealed practitioners' recognising heightened anxiety at both a professional and private level. Practitioners also described a sense of how fragile life is and beyond our grasp to control.

  "I am clear about not working with someone who is at risk". (Participant 33)

  "In private practice, I am very cautious as I feel more exposed and at risk of complaint if I have not judged a situation correctly and the client ends their life while in therapy". (Participant 59)

  "I am more anxious as a parent - if my child stomps upstairs and slams his door, I have a fear of suicide that I didn't have before". (Participant) 73

- **Change in attitude or behaviour** exposed practitioners' thoughts about complacency in other professionals or noticing a cynicism within themselves towards suicidal clients. Some wrote of being "hardened by the work" or experiencing "desensitization". One practitioner stated she was a Christian and the work with suicidal clients had deepened her faith, commenting "I sometimes find the work depressing but have learnt to pray for these patients, then "let go". This helps keep me sane"!

  "It has made me more cynical towards some people who attempt to take their lives, but I am trying to change this and work towards achieving a better understanding of why this happens". (Participant 64)

Question 26

In this question participants were asked if they had any further comments or information they wanted to convey. Two themes were identified and they were privilege and challenge.

- **Privilege** indicated practitioners' sense of working so closely with clients who were able to share their darkest moments. Practitioners referred to the rewards they personally gained from working so intensely with clients.

  "As painful and threatening as it felt to sit with this level of hopelessness and helplessness that presents with suicidal ideation, I feel privileged to have shared this

with those who have shared this with me; and I learned slowly that the 'therapy' was in this sharing of my client's experience more than any resolution as such". (Participant 34)

"I find it an absolute privilege when a client is able to mention suicidal thoughts. Never before have I had in depth conversations about suicidal methods and exploring and unpicking a client's story of why they want to do this". (Participant 42)

- The theme of **challenge** included the complexity of the subject of suicidal clients from a theoretical, moral and ethical perspective. Participants reflected on the balance of risk assessment and its impact on the therapeutic relationship, along with the principle that however hard one may try to prevent suicide occurring, on occasions the determination of the client will prevail. Within this theme there was recognition of the need to have appropriate training and support to sustain the practitioner.

  "We can become "blasé" about it and stop monitoring our own thoughts and emotions because it all becomes "too painful". As professionals, we need to process these painful thoughts and feelings (both formally, via Supervision and informally, including conversations with colleagues) or we burn out and suffer with Compassion Fatigue etc." (Participant 12)

  "I think suicidal clients and our fears and concerns about them are often an area of taboo within psychotherapy and the helping professions. It is often the dreaded meta-fear that follows us around, but can feel shaming to admit to. I guess it's the fear that if one of our clients kills themselves, what does that say about us and our work". (Participant 101)

5.7 Summary

In this chapter I have outlined the findings from the survey questionnaire both from a quantitative and qualitative perspective.

The ratio of male and female participants taking part in the survey appeared proportionate to statistics provided by the BACP, in relation to counsellors and psychotherapists on their

membership. Although a majority of participants recorded their profession as either counsellor or psychotherapist, the data still provided a good range from other professions working in a variety of settings.

All practitioners had experienced a client presenting with suicidal ideation; 85% of participants had experienced their clients making suicide attempts, and 31% had experienced the death of at least one client from suicide.

The findings demonstrated that practitioners found their work with suicidal clients challenging on a number of levels. There was a need to remain professional whilst under a distinct pressure, which in turn caused an inner conflict and vulnerability for practitioners. Working within the area of mental health requires, maintaining confidentiality on highly sensitive issues, on terms agreed with the client, and the practitioner works alongside the client to support them during their time of personal crisis. It would appear that difficulties can arise for the practitioner in relation to the pressure of the work impinging on their own personal life, mental health and wellbeing.

Following client suicide attempts, a wide array of thoughts and emotions were provoked in practitioners. It is clear that every experience is different- even for one practitioner there can be differing responses to various suicidal clients. The polarity of views was apparent, with some practitioners expressing satisfaction for a job well done in seeing their client come through a time of suicidal ideation, to others commenting on feeling completely out of their depth and unprepared.

Adjustments were made by practitioners following their client's suicide attempt, demonstrating an increase in activity afterwards. This may be as a result of practitioners following organisational policies or procedures, in order to not be found negligent if investigated. It may be just good practice to ensure that everything possible has been done to ensure the client is safe. However it may also be driven by anxiety, based out of a desire not to demonstrate failure, or to be found 'not good enough' as a professional.

Of the 31% of practitioners who had experienced the death of at least one client from suicide, the findings show that they had similar thoughts and feelings to those practitioners who had worked with clients making suicide attempts. However, for the practitioners whose clients had died there was a greater sense of self questioning, blame and expression of guilt.

These practitioners also reported making adjustments to their work following client suicide, but there appeared to be greater levels of self-support in the form of taking time off work, rather than working late, cancelling some planned work and having personal therapy where necessary.

The findings showed that support from managers was deemed to be good to excellent by 66% of participants, and support from supervisors even higher with 89% of practitioners reporting it to be good to excellent.

The adequacy of training had a greater dispersion of results –less than half (49%) of practitioners indicated their experience of training as good to excellent. Many participants provided areas of training which they had personally valued, and suggested ideas of topics which could aid future training provision in this area.

My personal experience of implementing thematic analysis on each of the open questions was extremely challenging. I found the volume of data far greater (in both quantity and quality) than I had anticipated. At the outset of this process, I imagined that analysis of the survey data would be completed in a matter of weeks, rather than many months. The depth and openness of participants' responses caused me to value the process of analysis to a much higher degree. Whilst the data clearly indicated that client suicide is not something which is easily forgotten, I too knew that the impact of the information I had encountered would continue to throw a shadow over me long after the task was complete.

In the next chapter I will highlight the findings from phase two of my research when I examined the interview transcripts using narrative analysis.

Chapter Six: Findings from Phase Two Interviews using Narrative Analysis

In this chapter I will present the findings from phase two of the research. One of the aims of the research was to hear the stories of practitioners speaking about their personal accounts of client suicide. By gaining an understanding of how these events impacted on practitioners, I could then produce training products which would be relevant to the profession. The findings from the narrative analysis are based on a sample of the material which will go on to contribute to a publication of practitioners' personal stories.

A simplified version of narrative analysis was used to analyse each transcript, as explained in Chapter four.

Stage 1: attending to the experience

Stage 2: telling the story

Stage 3: transcribing the story

Stage 4: analysing the transcripts

Stage 5: writing the report

I followed Riessman's (1993, 2008) method of analysis by firstly writing a brief introduction to each of the participants, including an outline of the participant's work situation, and the circumstances of our meeting. As I became familiar with the transcript I made notes on the overall structure of the story, the co-construction between the participant and myself, and the various voices and themes within the stories.

In light of the word count limitation for this thesis, it is not possible to tell the practitioners' stories in full; this constraint has led me to provide a summary of the content of the themes rather than fuller narratives.

I will now describe my findings from each of the eleven interview transcripts in turn. Table 17 outlines the details of the practitioners who were interviewed (names have been changed to protect participants anonymity).

Table 17: Phase Two Narrative Analysis Practitioners Profiles

	Participant	Gender	Professional Title	Experience of Client Suicide	Setting	Qualified or Trainee
1	Diane	Female	Counsellor	Yes	Private Practice	Qualified
2	Stella	Female	Psychotherapist	Yes	Private Practice	Qualified
3	Sonia	Female	Counsellor	Yes	Hospice	Qualified
4	Gill	Female	Psychotherapist	Yes	Private Practice/ Primary care	Qualified
5	Sophie	Female	Social Worker	Yes	Secondary Care	Qualified
6	Paul	Male	Psychiatrist	Yes	Secondary Care	Qualified
7	Gemma	Female	Support Worker	Yes	Psychiatric Inpatient Ward	Trainee
8	Julie	Female	Nurse/ Counsellor	Yes	Secondary Care/ CAMHS	Qualified
9	Andrea	Female	Counsellor/ Drug and Alcohol Worker	Yes	Drug and Alcohol Service	Qualified
10	Joan	Female	Psychotherapist	Yes	Secondary Care	Qualified
11	Karen	Female	Psychotherapist/ Clinical Supervisor	Yes	Secondary Care	Qualified

I will now outline each of the narrative shared by the practitioners; my first interview was with Diane.

Diane's Story

6.1 Introduction to Diane

Diane was a qualified counsellor who had been working in private practice for more than a decade. I met with Diane at her home, and she took me through to her consulting room via the kitchen, where she made me a drink and commented on her dog who came to greet me. Diane mentioned that her dog had been there on "*that day*", referring to the day she found out that her client had taken his own life. As Diane showed me into her consulting room she explained that her clients access this room by a side door. Diane appeared a little anxious, but at the same time she came across as kind, thoughtful and attentive. Our meeting together on "this day" seemed important for us both. Diane made reference to the fact that she had known I would contact her to be interviewed, and for me it was the first research interview.

Below is an extract taken from partway through my interview with Diane, in which I used a stanza style of narrative analysis to depict the conversation. My reason for choosing a stanza style in this instance is that it captures the rhythm and poetic intonation of the spoken word, in a way that traditional transcription sometimes loses. Stanza style also highlights pauses and silences, and communicates the emotion contained in the account (Mishler 1991, Gee 1991, Richardson 2003, Etherington 2007 and Riessman 2008).

> *I think I was working so hard on that, I didn't pick up with him on the depressed side.*
>
> *We talked about him working in an allotment that he has,*
>
> *and we likened that to a symbolic nature as to how he would like to make things grow.*
>
> *He would start off with this enthusiasm, and then he would forget to water it*
>
> *and it would come to nothing.*

He would be terribly disappointed.

Then the 5th appointment would have been a Bank Holiday, and I discussed with him about how he felt about missing, and he said he didn't think it would be a good idea.

So we agreed to meet on the Tuesday instead and he didn't turn up.

I wasn't particularly worried.

I thought maybe he had forgotten we had made this different arrangement,

I think, I did what I normally did, was to contact him after the session by email.

I think I sent a very short email saying I was sorry not to see you and

perhaps there was confusion about the dates or something,

but I will see you next Monday for your regular appointment.

And I obviously didn't get a reply.

So that was the Tuesday and I think on the Wednesday I got a letter from him,

typed but personal to me,

thanking me for all I had done, and that by the time I read this he would be dead.

He had decided to kill himself, and he said I couldn't of done any more.

He always felt better after our sessions, but in the end he couldn't manage to go on any more.

I've got the letter if you want to see it.

I guess there was an element- when I look back at working with him,

-especially the last few sessions here -that it can't really be true that he was suicidal.

I suppose I didn't want to believe it.

I suppose what I have questioned myself over it is why I didn't take him up more on it.

6.1.1 Structure of Diane's Story

Diane spoke quietly and initially tentatively, as she outlined her relationship with this particular client. Early on in their relationship the client had asked Diane if she was nervous with him. This comment had startled Diane, as she was not aware of feeling nervous. However, there was clearly a strong dynamic present, as the client referred to himself as "I'm difficult", "I am hard to handle" and "I will need more from you". Diane reflected on their relationship and wondered if he set people up to fail.

Diane told her story for about fifteen minutes, until she came to a place in the story where she was questioning herself. There was a vein throughout Diane's account of soul searching, reflecting on what had taken place and her part in the "mystery".

The middle part of the story revolved around the suicide letter from her client, which Diane kept in a locked box, and it seemed to serve a number of purposes for Diane. Diane recalled that:

> *"it always gives me a sort of heart stopping moment", "I feel I need it there, I don't want to get rid of it because it would be getting rid of him completely", "It makes me feel quite emotional", "It was a very personal letter, he had thought about it, I think he was trying to say it's not your fault".*

This phase of the story then moved on, as Diane spoke of how she had kept going as a counsellor, and how she had been changed by the experience.

Riessman (1993) identifies the need for the researcher to consider why the participant tells her story in this particular way with this listener. Diane came across as self-contained and professional. She had not spoken with many people about the suicide of her client, and yet this interview had provided an opportunity to speak in a professional context to a stranger. Diane had been trained as a psychodynamic counsellor, and she spoke of the importance of speaking to me, as I came from the same training background. This was an interesting point, since at no stage did I mention my own training orientation. I wondered if Diane thought someone from the same professional background would understand her more fully. Diane spoke openly about her own soul searching, and I found hearing Diane's story extremely

moving. At times during the interview I felt as if I was a priest in a confessional booth, as Diane spoke candidly about her experience, and these moments were very humbling.

6.1.2 Co-construction of the Story

In setting the scene for the interview I invited Diane to tell her story in any way which felt comfortable. Diane portrayed the story slowing and gently, until she reached a point of deep self-questioning. It was at this moment that I intervened with a reflection on Diane's countertransference response.

Diane used powerful words to explain her story such as "*he somehow anaesthetised me*" and "*I felt as if I were sleepwalking*". Rather than asking questions in relation to these statements I asked Diane to say a little more. This seemed to provide Diane with a platform to describe, examine and link imagery to her thinking.

There was turn- taking during the story, but questions did not play a significant part until later in the interview. There seemed to be mutual respect and an appreciation of what the other person was contributing.

6.1.3 Voices in the Story

Diane expressed the voice of defeat, helplessness, puzzlement, resolution, strength and resilience. But as Diane recounted her story she also brought in the voice of her client with his sensitivity, vulnerability and determination.

Another voice which could be heard in Diane's story was the anger in the client's sister who phoned Diane to inform her of her brother's suicide -"Well he has done it finally- I hope he is satisfied". There was also the formal voice of the duty doctor at the client's surgery, who questioned Diane to see if she had permission to contact him. The doctor conveyed how upset the client's registered GP was, and this caused Diane to feel alienated and possibly blamed.

The voice of Diane's clinical supervisor was a significant voice in her story, as Diane spoke of how she had phoned him when she received the suicide note. Her supervisor had been driving when Diane phoned, and so pulled over into a layby to ring her back. As he was

about to listen to the voice mail from Diane, he had an epiphany moment, in which he had the sensation that another vehicle had come up from behind and was going to smash into his stationary car and this caused him to gasp out loud.

6.1.4 Themes within the Story

Blind spots

Diane had carried an awareness of how depressed her client had presented, yet for some reason she did not really address the depression as was her usual practice. Diane had worked with other depressed and suicidal clients, but with this client she described a sense of being aware of his depression, yet "he was almost lulling me to sleep with it as well". Diane went on to report that her experience of the client was:

> "*I'm telling you I'm depressed and I've thought about suicide but I'm not going to let you really get in there"*.

This strong transference and countertransference communication caused Diane to question herself ruthlessly. Diane was perplexed as to why her usual sensitivity to her own countertransference responses was inactive.

Torment

When Diane received the letter from her client she recalled:

> *"I remember walking around the kitchen and saying to the dog, I can't believe it… he couldn't have… I can't believe it- not really knowing what to do with myself".*

Diane immediately rang the client's GP as she had the fantasy that her client may still be alive in his home, perhaps having taken an overdose. Diane then had a struggle of not being able to get in contact with the GP, and having to wait with the uncertainty of not knowing for sure if her client was alive or dead.

Questions such as "Could I have done more"? "Did I let him down?, feeling puzzled why I did not do more" all contributed to an internal struggle which Diane went through. This inner torment was verbalised during our interview, with Diane saying such things as:

> "*I haven't solved the mystery", "I haven't found a resolution in my own mind about my part in it", "and I think I should have said to him, I am very concerned about you"*.

Although time had passed since the suicide of her client, Diane remained a prisoner to this battle in her mind.

Survival

Yet despite Diane's turmoil she acknowledged that "*the worst thing that could happen has happened*'', and she was still able to work as a counsellor. Diane reflected that in the early days after her client's suicide, she had wondered if the event would end her career and she would have to stop being a counsellor. Yet Diane had been supported at a personal level by her partner, and at a professional level by her supervisor. Diane was acutely aware of the strength of these relationships in providing what she needed, at the most challenging moment of her career. Towards the end of the interview, Diane reflected that as dreadful an experience as it had been, in some way the "searing" which took place had made her a better counsellor.

Diane belonged to a helping profession where her training and experience had prepared her to support, care and help clients who were facing mental health problems such as depression and suicidal ideation. In this culture of support and recovery Diane had devoted herself to working with many clients.

Within the society in which Diane resides, the general expectation is that we live until we are old- unless we are unfortunate enough to become ill and die. Diane's client however, chose to act against this societal norm, and when he chose to end his life, the relationship they had experienced was severed. Diane had no opportunity to discuss this ending with her client, and was left outside of his decision making. There was no further opportunity to make sense of his dilemma together, and Diane was left on unfamiliar territory.

Diane's story highlights the pain and soul searching she faced in the days, months and years following her client's suicide. Diane's story portrayed the resilience and courage she had

developed which enabled her to face her worst fear and yet continue to be a 'good enough' counsellor.

Stella's Story

6.2 Introduction to Stella

Stella had worked as a psychotherapist in private practice for many years. When I entered her house, I did so via a side entrance which took me straight into a small cosy room, which Stella used for her client work. Stella was a well-travelled and confident character.

6.2.1 Structure and Co-construction of Stella's Story

Stella spoke at length about two sisters she had worked with at different stages over the past ten years. Jane had been a client of Stella in the past, and had approached Stella to enquire whether she would see her sister Claire, who was experiencing suicidal ideation. Stella worked briefly with Claire, and sometime later Jane returned to have therapy with Stella following the suicide of Claire. During this period of time Jane declined in her mental health, and began to not attend her sessions. Stella acted out of character, and went to Jane's home when she became unwell. Stella's intervention resulted in Jane being admitted to a psychiatric hospital, and following her inpatient treatment Jane returned to have counselling with Stella.

There was a significant event for Stella mid-way through the interview, where she had an epiphany moment, and became visibly moved. For a considerable part of the session Stella conveyed a sense of self-assurance.

At one point Stella said:

> *"I do know about myself and I don't panic in a crisis- I mean I had a burglar here once and I got up and talked to him- I am amazed sometimes what you can do in a crisis".*

Following the interview I reflected on why Stella portrayed such a sense of self-assurance. I wondered if she was just a strong character of if she needed to present herself in this way. I noticed that there were moments when contradictions seemed to appear in Stella's story.

6.2.2 Themes within the Story

Ethics and boundaries

There were a number of occasions during our meeting when Stella spoke of ethics or possible boundary issues. The first time was when Stella said:

> "*This is going to sound a bit unethical, but I did check with my supervisor and we worked it through. She (Jane) asked if I would see her sister (Claire) as she was expressing suicidal thoughts- what she didn't know- I did take her on- but what she (Jane) didn't know is that she (Claire) had attempted suicide several times".*

While Stella mentioned "It may seem a bit unethical" a number of times during our meeting, Stella reiterated that at no time had she ever discussed either sister with the other. Stella worked with Jane on and off for ten years, and was keen to communicate that she had not allowed the relationship to cross the boundaries making it into a friendship.

Here is an extract from the interview:

> "*I would have loved to have asked her about her sister……..she did mention her on occasions, they did have their differences but what impact did her death have?…….. Well, it's sad isn't it and of course I am left with what wasn't done that could have been done or was it just meant to be? It is not my job to talk them out of it- to convince them it's the wrong thing to do. We must allow them to make their own decision, it's their life but to sit with them again…. sit with them to support them and that is what I did with her, sit with them, support them, don't abandon them but if she chooses to leave me, to go somewhere else……. If she chooses to do that, then that is her decision isn't it? I just, as I always do when something is unfinished, I say the door is open the phone is always there."*

Under an illusion

As Stella recalled the brief work she had done with Claire, she said:

> *"She convinced us that she was on the road to recovery, if such a thing can happen with a suicidal client and she was… I don't think she changed her mind… I remember the statement… next time I will make it work".*

Stella seemed to be saying that Claire had indicated that she was feeling better and "on the road to recovery" yet there is the contradiction as Stella recalls in Claire stating "Next time I will make it work". Stella also says "She convinced us" as if both Stella and Jane had been under an illusion about Claire's suicidal intent.

Stella's working relationship with Jane took place over a ten year period with some breaks. Despite Jane mentioning early on in therapy that she had attempted suicide many times, Stella failed to remember this. Stella stated that "it got buried" and "she was under an illusion or in denial that this would happen again".

Stella spoke of her supervisor prompting her about Jane's previous suicidal attempts, but then remembered that her supervisor had moved away, and in fact there was a period of time when Stella did not have a supervisor.

Acting differently

Stella recognised that when Jane missed several sessions, rather than just let it go she did something very different to her usual practice. Stella phoned Jane and asked her if she would like her to come to her house. Stella recalled sitting on Jane's bed, holding her hand and listening to Jane say that she wanted to follow Claire. Stella mentioned to Jane the possibility of calling the GP. Stella did contact Jane's GP, and later that day Stella was informed that Jane had been admitted to a psychiatric hospital.
Stella reflected that she was relieved that she had taken the extra step:

> *"I was not abandoning her- I wasn't waiting for her to come here so I could collect my fee. It was beyond that… not abandoning is a very important word I think".*

There was something very intimate and tender in the way Stella described her time in Jane's house.

> *"She looked at me like a child… I was the mother in that instance, the mother she didn't have, the caring mother and I think I fulfilled that role. I wasn't conscious of it at the time, but I'm conscious of it now that you have asked me, in fact I've got a strange feeling going through me as I'm saying that, because I wasn't aware of it at the time, and then not to be abandoned, her words not mine…..not only was I a mother to this client, I was my own supervisor".*

Stella had a strong belief that as a therapist, it was not her place to try and change the client's mind if they wanted to take their own life. However, in visiting Jane and calling the GP had she in fact saved Jane from suicide? Stella reflected that had Jane died she would have had different feelings to when Claire died. "*I think I would have been sadder, tearful and had to work through that*". Stella thought this was due to the length of the relationship she had had with Jane…

> "…s*o perhaps a different quality…. Yes, we had a different relationship, one I bonded with- or she bonded with me- and the other one, yes and no but superficial".*

Sonia's Story

6.3 Introduction to Sonia

Sonia was a qualified counsellor who also managed a team of counsellors within a voluntary agency. The role required Sonia to mentor, supervise and deliver training to her team. I met with Sonia at her home late one sunny afternoon. Sonia gave me a warm welcome and we sat in her dining room for the interview.

6.3.1 Structure and Co-construction of Sonia's Story

Sonia started her account by explaining the context in which she worked, and the types of clients that she worked with. It was clear from the way she spoke that Sonia was passionate

about her work, and had a real respect for her client group. Sonia explained that the lady she was going to speak about was already known to her, as they had met at the agency previously in another capacity.

Sonia outlined how difficult the counselling work with this lady had been, partly due to her sense of hopelessness following the death of her husband, and partly due to her silence.

Though Sonia appeared to speak with ease, part way through our session she mentioned her concerns about how much to share with me. In opening up to me, Sonia wondered what the repercussions might be for her. Would she be struck off by the BACP? Would she see her name in Therapy Today outlining her misdemeanours? Would she be arrested? Would I judge her?

While Sonia said nothing that would warrant such dramatic consequences clearly she carried a sense of burden, guilt or being 'found out'. I was intrigued by Sonia's concerns and although I did not reassure her, my hope was that by speaking with me, in some way she would find her own peace.

6.3.2 Voices in the Story

The voice of utter sadness came through from Sonia's client over the death of her husband, and how life without him just was not worth living. Sonia said "*Why would she want to keep breathing, if he wasn't here*"? The client had a strong religious faith in which she believed that she would meet her husband in heaven. Despite her advancing years, and even acting out of character, the client's determination to be reconciled with her husband perhaps drove her to take her own life and with an assured method.

Sonia voiced her own sense of horror at the method her client chose to kill herself.

> "*I think the way she did do it was so shocking for a lot of us because she hung herself and I think that for me was very, very difficult because it seemed so, I know it sounds silly, but out of character, because to me and this is a personal thing to me, hanging is brutal…….you have to think about it so much, you have to….I mean just to think about finding a joist that is strong enough, you have to find the right rope. I wouldn't*

know how to make a noose and it seems there was so much to think about before and it just seems so violent and she was this lovely prim contained lady that, I don't know, wouldn't there be a gentler way of doing it?''

"…I think it was the way she did it, I think for me if I said any emotion, any thought was the biggest, it was how she did it… but if think about it, every way is violent isn't it? And that's what I learnt from this experience, is that every way of suicide is violent, erm…I suppose the best form is taking tablets maybe, but yeah, I think it was the way she did it and the thought that went into that… because I'm thinking if you go and get tablets, you just go to the chemist, buy some tablets and go home but she must have got step ladders out".

The voice of the wounded counsellor came through when Sonia questioned herself. "*Was I a good enough counsellor*"? and "*Could I have done more*"? Interwoven into the story of her client's suicide Sonia spoke of one of her own relative who had hung himself. It seemed that the death of her client brought back troubling reminders of her relative's suicide, through comments such as "*I've always felt terribly guilty about his suicide*" and "*Could I have done more*"?

6.3.3 Themes within the Story

Determination

Sonia had a medical background and reflected on the human desire and determination to live:

"It amazes me when we have a lot of patients who are just completely riddled with cancer and they get a cold, and their body fights the cold off… I always think that's really amazing… so the body keeps functioning and wants to work".

Sonia then went on to consider how difficult it is to kill yourself, as the human body wants to fight for life. When Sonia spoke of her client she thought the lady must have had a tremendous determination.

Initially, Sonia felt an intense sadness for the loss of her client, but as time passed she said:

> *"I started to feel, almost joy for her, in that taking all of those things into account, she still went on and did it… erm….so I think I felt a certain kind of peace from that, in that I think she must of really thought it through".*

Retribution

I was taken back by Sonia's fears of being 'found out': she reflected that when the interview started she thought:

> "*I'm thinking how honest can I be?, what's going to happen to this tape?, and then I thought, actually, I can't, there is no point in you driving all this way is there if I'm not sharing- I'm sure you're not going to report me for anything… and I'm thinking… but I've done nothing to report*".

For Sonia she had sought help on different occasions from the BACP, and felt very let down by them. I think this had led to her stating:

> "*They have always frightened me a little bit and that name and shame page in that magazine…It's a bit like, you know when you're little and you see a policeman, and you think what did I do, what did I do? Well, there is no great big thunder clap, nobody came in and arrested me and threw away the key".*

Sonia shared that as a "*culture we are terrified of death*" and as practitioners working with suicidal clients we are also "*terrified of being struck off*".

Resilience

Sonia had experienced perhaps one of her greatest fears -that of her client killing herself. This was also made worse by the memories of her relative taking their own life, and the guilt that she felt in relation to that event. Yet, despite these challenges she continued to work as a counsellor and continued to support her volunteers and colleagues; Sonia also supported the client's GP who was very upset following the suicide and whom Sonia had worked very closely with during the clients counselling.

"She had taught me an awful lot……I'm sure that wasn't her intention, I don't know, but she really has, she has really given me permission to be freer and not be so frightened".

Sonia's client had taken her own life, and this had profoundly impacted her, yet Sonia knew that the event had not broken her beyond repair; instead it had made her 'Braver' and given her a 'Courage' that she had lacked previously.

Gill's Story

6.4 Introduction to Gill

Gill was an experienced psychotherapist working in both private practice and as a trainer; she also had previous experience of working within a secondary care setting. I met Gill at the venue she rented for her client work. In the way that Gill presented herself to me, there was something very grounded and mature about her- her presence and the environment where she worked felt very safe.

Gill had had two experiences of client suicide in two different contexts.

6.4.1 Structure of Gill's Story

Gill set the scene by explaining how she came to work with one particular client, and the referral route by which he came. Gill shared how from the very beginning she was aware of the severity of his suicidal intent, and how it was not her usual practice to work with someone so unwell, and who also had the means and the knowledge to kill himself. However, Gill possessed a sense of obligation to the colleague who made the referral, which she felt added to the complexity of the situation in some way. Despite her reservations, Gill knew her client had the support of his psychiatrist, who was trying to have the client admitted into hospital.

Gill told the story in a slow and deliberate manner, pausing on occasions to reflect. Gill explained the story of this client from beginning to end, before interjecting other experiences of working with clients who had attempted and taken their life by suicide. When Gill had completed her narrative of the first client she stopped and said "*That's the story".*

6.4.2 Co-construction of the Story

When Gill had completed her first outline of the story, I was overwhelmed with a sense of how difficult it had been for Gill not only to work with this client, but also the huge sense of obligation she felt to work with him despite her reservations. During this phase there was more turn taking between us as I enquired further, showed curiosity and sought clarification. Gill spoke powerfully of her awareness of the strong possibility that her client would kill himself, and she reflected "*So, I was not working in the dark*". Whilst listening to Gill I endeavoured not to fill the gaps in her story with my own interpretations, but kept gathering her ideas and thoughts with regard to meaning.

Gill spoke of how difficult she found processing her thinking in the weeks following her client's suicide. If the death had been a friend or family member Gill could have spoken more freely, but as the death related to her client, speaking openly was not an option. Although Gill had good support from her supervisor, she used a powerful metaphor to describe how trapped she had felt at that time:

> "*It was almost like a bomb going off in an enclosed room".*

Despite knowing from the outset that the client had a significant risk of suicide, she had battled on and believed that real progress was being made. Yet during this time of apparent progress the client chose to take a fatal overdose.

At times during our meeting I had very physical reactions to what Gill shared, such as a chill going down my spine. At these moments, when appropriate I disclosed what I had felt, and made enquires which opened up the story further.

6.4.3 Voices in the Story

The voice of compassion was communicated powerfully in Gill's narrative, not just for her client, but for those whom the client had left behind. Gill spoke of her intense sadness for his partner, his children and the professional who had referred him. The care with which Gill spoke of her colleague came as a surprise to me.

Obligation came through strongly, as Gill described going against her better judgement and taking on a client who really needed to be an inpatient. The colleague who referred the client believed that Gill could make a difference, and Gill reflected:

> "*…I felt I was trying to save him on someone else's behalf*".

There was also the awareness that Gill had in some way set herself up for this tragedy, by agreeing to work with the client. As the client had the support of a psychiatrist Gill felt a degree of self-protection professionally, but as she thought back on the events she commented:

> "*But I still do think in hind sight, what stopped me saying no?"*

6.4.4 Themes within the Story

Timing

Just at the moment when the client was due to arrive for his session, Gill received a phone call from the colleague who had referred him, saying the client had taken his own life that morning. Gill commented:

> "*It was a weird thing …when the phone went and I saw who was calling, I did actually think oh no- I wondered straight away".*

Gill spoke of her initial feelings, saying:

> "*I felt such an overwhelming sense of helplessness" and "It was a huge interruption of something really difficult……it was as if he had come into the room, and I remember just being a bit stunned really, and was just sitting here…I was glad I was*

here- I was glad I had time to just absorb the information in his time as it were ……it was very appropriate, he couldn't have timed it better for me".

Gill seemed to have a real gratitude that she found out about his death actually during his scheduled session. There was a unique opportunity for her to literally use 'his time' to contemplate what had happened.

Gill did have a gap in her diary that day, but went on to meet several other clients later that day as planned. Gill reflected that the time gap was "*fortuitous*" and said,

"*I don't think it affected how I would be with them, but obviously there was something going on for me, but I don't know if that would have been communicated or not".*

Saviour

Gill spoke of the obligation which she had felt to work with the client, and the powerful impact that the event had had on her. Gill said:

"I recognise in myself and I see it in other professionals….is that kind of…. probably a rather omnipotent grandiosity… but there is a sort of hope that you are going to be the person that saves them".

Gill is noticing the tendency within practitioners generally, and herself, to reach out in an attempt to save or alleviate the pain of the client. As already mentioned Gill said:

"*I felt I was trying to save him on someone else's behalf*".

Again Gill was indicating a sense of obligation to save her client from suicide, at the request of her colleague.

I was interested to see how Gill showed care and compassion to the colleague who referred her client. Gill met up with the colleague following the incident, and on subsequent occasions to check her wellbeing. The colleague was clearly very upset, and did apologise for the referral and its' outcome. Some practitioners would have felt that they had been set up or dumped upon by the referrer, but Gill, despite her own pain, demonstrated a need to protect or rescue her colleague.

Reputation and pride

Reputation was present for both the client and Gill, since the client was a senior health practitioner, with a specialism in mental health. The client therefore knew the system, and Gill reflected that "*he was very clever at getting others to collude*", being adamant that he did not want to be hospitalised. He did everything in his power to guard his reputation; Gill stated that:

> "*…we were all paying attention to his professional pride and sense of integrity, and the last thing he wanted was to have this mental health record*".

Gill went on to say,

> "*…we were all somehow or another drawn into his very complicated and elaborate world".*

As Gill embarked on her work with this client, she had real concerns that if he killed himself it might impact on her own reputation- and would it be damaged? For Gill, there may have been aspects of personal pride in the fact of being asked by a colleague who had sought her out- who perhaps had observed in her the ability to work with, and to contain the strong suicidal desires that this client was experiencing.

Sophie's Story

6.5 Introduction to Sophie

Sophie trained as a social worker, and worked within a Community Mental Health Team. Sophie worked with adults who have severe mental health problems, such as personality disorder, schizophrenia, manic depression and bi-polar disorder. In addition to having her own caseload, Sophie had responsibility for supervising other team members.

Sophie and her team had experienced a significant number of client suicides over the years, due to the severity of their presentation. As a supervisor, Sophie has also had to support

team members following the death of their clients, and also liaise with bereaved family members following client suicide.

I met with Sophie at her home to speak about her experiences of client suicide.

6.5.1 Structure of Sophie's Story

Sophie commenced her story by outlining her first experience of client suicide, when as a qualified social worker she moved into a mental health team. Sophie had worked with one particular client for several years, who had severe and enduring mental health issues. Sophie reflected:

> "*I think when she did kill herself, it was very much of a shock…she often said these things, but we never thought she would actually do that, and I think the way that she died as well, I think that was a very violent method -and again that was a shock because I don't recall her ever tying anything around her neck or anything like that, it was just….yeah, it was very sad actually".*

Sophie then brought the story into the present, and spoke of recent suicide experiences within her team, the varying roles she had played in the support of others and the impact this had on her.

Towards the end of the interview when I asked Sophie about her experience of speaking with me, she reported how helpful it had been to consider her first client suicide, and made the link that "*She is still influencing my practice*". The opportunity to think more deeply had also helped Sophie to recognise a need within herself and the team, to have time to reflect.

6.5.2 Voices in the Story

Sophie recognised the human frailty and vulnerability that her clients possessed. There was a voice in the background of the vulnerabilities within the team, which were triggered by the intensity of the level of support clients required. An additional voice was the anxiety of senior management, and their concerns for organisational reputation.

6.5.3 Themes within the Story

Mixed messages

One of the mixed messages which was present in Sophie's story, was that of the contradictions which can present in clients' stories. Sophie spoke of clients who present as being high risk, and team members then doing all they can to support them, only to find an hour later, that the client has gone off to the shops, or is doing something that would seem very contradictory to what had previously been expressed. Sophie thought that this could leave practitioners confused as to the true level of risk, and uncertain about their own decision making.

Sophie reported that over the previous few months, the team had experienced several suicides which had been extremely challenging. In response to this, senior management had sent a communication which initially appeared to be very supportive, thanking the team for their hard work. However, the second part of the communication stated that whilst senior management understood the difficulties the team had to deal with, they must make sure that their decision making is reasonable, and that everything is fully recorded. Sophie reflected that the thanks of the first half became marred by the warning in the second part of the message. Sophie thought this mixed communication…

> *"…breeds a kind of anxiety …so maybe…..you have to be a bit guarded when you respond to things…I think that culture can develop and I think that's quite negative really".*

Difficult conversations

Sophie mentioned some of the difficult conversations she had had to have with family members, following the suicide of clients. It can be common for families to blame the professionals involved, when they feel that not everything has been done to keep the person safe, or that mistakes have been made.

Sophie spoke of her anxiety about giving her condolences to one father, only a few hours after the suicide of his son. Sophie was feeling extremely anxious about the conversation, particularly as she had never met the client, and did not have all the details concerning the death; she was also apprehensive about how the father may react towards her.

"*The conversation went really well and actually his father was very grateful to have somebody to talk to. I think being able to talk about what had happened, the questions that he had about his son, and his son's death and what had happened prior to his son's death, and the treatment that he had had from our Team. Although I wasn't able to…it was a very difficult situation because I wasn't sure about confidentiality and how much I could disclose to this father about his son…I mean his son was in his 30's, so I felt a bit guarded about what I said because I had to respect the client's confidentiality. I wasn't sure how much to say, but on the other hand I didn't want to leave this poor father with a kind of…'no comment about that'…so it was kind of difficult, but I felt that I was somebody who he could say exactly what he felt to, and he could talk about how the family was responding to that, and so I felt that I was a useful listening ear in some way".*

Sophie stated that once she had written her notes up on the conversation she breathed a sigh of relief.

Sophie spoke of another client she was working with who had significant issues, including extreme harm to self. Sophie spoke cautiously, as she recounted some of the ways in which the client harmed herself; it was clearly not easy for Sophie to speak about the levels of harm that this client inflicted upon herself. Sophie recalled a recent phone call from the client to the team, where the client was walking along a railway track. The colleague who took the call could hear the train coming, and was telling the client to get off the tracks. Fortunately, the client did get off the tracks, but the colleague could hear the train braking and the train driver shouting, and she was still trying to offer support to the client in very difficult circumstances.
These types of incidents were very hard for the individuals involved to witness, bear and support each other.

Team approach

What became apparent during the interview was the value of having a team approach to client care. Following difficult incidents, some team members did come together to talk about the events, and to ask whether anything could have been done differently. Asking

"Could we have done anything differently" felt like a shared responsibility and less of a burden on individuals.

Sophie thought that being part of a team meant that when she had concerns about clients being at risk, she had been able to ask the team to continue to have links when she left for the day.

> "*When I walk out the door, actually the caring goes on when I go home*".

This was valuable not just for the client's wellbeing, but also for Sophie.

Sophie felt personally supported by the team, and her manager. She had monthly supervision, and knew that if she needed to talk she could, and would be able to approach her manager.

> *"I mean …we have some quite difficult situations, and that's an opportunity to talk through… so that's helpful as well… so yeah, I think supervision is a positive part of coping with the work.''*

However, Sophie did also recognise that being part of a large team was a challenge in itself, and that communication related to serious incidents and support were not always right.

Sophie observed that it was not always possible to be completely honest.

> "*You know, when things happen at work, you almost feel 'I've got to be professional about this'. So I can't actually say, that's really upsetting me or you know to actually say …could we have done more?*"

Sophie outlined how the managers inform their deputies when a client takes their own life, and then the deputies disseminate the news once the people who had been directly involved had been informed. The incident is then discussed in the team meeting. Sophie wondered if this was somewhat impersonal, and could possibly be communicated in a more sensitive way. Sophie did not think it was always very well thought through, and had a tendency to come across as matter of fact.

Following a serious incident, the investigation had highlighted the need for staff to have a reflective space in which to process their thinking. However, management did not think the

time could be spared. Sophie considered the impact that some of their clients who were seriously self-harming, or who had killed themselves had on the team. Sophie went on to say that these events…

> "…c*an lead to people being off sick… you know some people can't cope- I mean I know on the wards some nurses have chosen to change to different work… you know choosing different wards to work on because they can't manage the stress. We are actually losing really good staff, even if that is just for a period of time, when they feel they need to have time off. I think if that thought of a reflective space was available, I think that could make a difference".*

Sophie went on to mention how within her team, people were off work with depression and anxiety.

> "*I think if you have issues with anxiety, the sort of clients that we work with can raise that anxiety even more, and you know, I can sometimes feel like it's getting to me… I need to talk to someone about that, or do something else, but try not to be anxious".*

Paul's Story

6.6 Introduction to Paul

Paul worked as a Consultant Psychiatrist, and we met in his office at the hospital where he was based. Paul was an experienced clinician, who had worked in many healthcare settings over the previous three decades. His office walls were lined with shelves which were crammed with books, journals and files; every inch of space seemed to be filled.

I invited Paul to speak about his experiences of working with suicidal clients. Paul leaned forward in his chair, took a moment as he gathered his thoughts, and then started his story.

6.6.1 Structure of Paul's Story

Paul outlined his career path and the reason for his career choices. As he spoke of the varying contexts, settings and stages of his career, he wove in his encounters with patients,

colleagues and friends who had been suicidal. Paul spoke slowly and thoughtfully throughout the session.

Paul ended his story by making a statement about the need for support rather than blame, following a patient suicide.

> "*Statistically, every so often a person does go on to kill themselves, so I think it is having the confidence to make decisions, but also knowing that if the outcome is a bad one, that you will be supported rather than blamed".*

6.6.2 Co-construction of the Story

I had a preconceived idea as to how Paul would present himself. I had expected either a trainee psychiatrist, or a psychiatrist with knowledge but without the ability to reflect, or with experience but possibly also arrogance: I was however surprised by Paul, because he conveyed warmth and kindness when he spoke about his patients. He did not come across as 'the expert', but as someone who genuinely sought to understand his patients' frame of reference.

I asked questions such as "What did you think about that?" and "Why do you think that happened?" These types of questions facilitated Paul in expressing his values and beliefs. In addition I asked about the support he received from family and colleagues, which allowed Paul to speak of the significance of the network of people around him.

6.6.3 Voices in the Story

The voice of the Sage came through in Paul's narrative, as he demonstrated wisdom, sensitive decision making, thoughtful judgements and a wealth of experience. Paul reflected back to his training, and said:

> "*When I qualified, you see, it was either sink or swim, you either got on with it or you went under, so I developed a sort of resilience and self-reliance, which is helpful".*

While this statement could convey arrogance Paul possessed the ability to be reflective and humble. He had not been worn down by the demands of work, and I think his resilience was a product of these factors, along with his work life balance.

"*I deal with quite a lot of emotionally intense work, and there is a need to switch off. Also I am very conscious that I need to give my family my time and not to bring my work back home".*

Paul observed that those who were "workaholics" may not be emotionally and physically present for their families, and he thought this was…

"…a bad thing, because you can't get those years back- so I think, probably if I had been less family orientated, I might have got through my training quicker, but wouldn't be able to get those years back. When my daughter was a little girl she wanted to spend time with her daddy, so when I was preparing for my exams, I would get up early and do the work then, so that when I came home in the evening, I would have more time".

6.6.4 Themes in the Story

Learning comes from staying with the challenges

Paul recounted stories of patient deaths which had occurred over the years; some had been suicides, whilst others were due to natural causes, or unknown reasons. He thought that overall there had been very few suicides in the light of the number of patients that he had worked with.

Paul commented:

"*When a patient kills themselves, it does create a reaction in you, and it is something that you need to come to terms with. I wouldn't say that I get extremely upset, but nevertheless its sends a sort of unpleasant feeling inside".*

Paul also compared his varying reactions to patient and colleague suicide. He thought that the loss was far more difficult if the patient was personally known to you. However, when colleagues and family friends had killed themselves, that posed an even greater reaction. Paul thought that the professional relationship gave some degree of emotional distance.

Paul spoke about complexity, and the challenges which some patients had created for him. Paul reflected back to when he was a trainee, and how one of his Consultants had conveyed

to him that he did not see the point in passing on difficult patients' to another doctor, because very often they would not settle. The Consultant suggested that the best thing for everybody was "to learn to live with each other". This view was something Paul had implemented in his own practice:

> "*I'm very reluctant to pass them on to somebody else……there is a continuity of care …but also there is a need to ask is there something wrong with the service? Does it need to be improved? But another thing is to say…. well they are difficult patients whom I could learn from…and make me think about my practice. If everything goes well, generally I haven't learnt anything. It's the very difficult patients I've had to sit down and analyse and discuss with others and see…… sometimes that has led to me changing my practice, and developing as a clinician, which wouldn't have happened otherwise. I think being able to manage your own anxieties is also very important, and it is true to say that some patients do produce an emotional reaction that is very strong sometimes. It is a reflection of how they are feeling, frustration, hopelessness, getting angry…those are some things you can feel, and for that I think it is very important to discuss with colleagues to get that sort of outside view*".

Paul spoke of the need for personal reflection, particularly when experiencing a strong reaction to the patient such as hate, hopelessness or frustration. This realisation had enabled him to deal more effectively with his patients, to stay with them and not to blame them for the strong emotions evoked in him, and not to blame himself.

> *"If something isn't right, I try to learn from it because unless you're honest in that way, you won't progress as learning can be uncomfortable".*

With very distressed, anxious, depressed and suicidal clients there can be the temptation to refer them on to another practitioner or service. However, for Paul, where possible he felt it was in the best interest of the patient and the clinician to stay together.

Decision making

Another theme which arose was that of decision making. Paul spoke of his time working in the Accident and Emergency department, and how he had had to deal with death on a daily basis. He iterated the necessity to make decisions…

> *"I think as professionals, we have to make decisions because there is no one else to do it and it does involve making judgements".*

Paul mentioned how hard it was in mental health assessment, to judge the patient's state of mind. One moment the patient could be feeling one way, and then their state of mind can change, leaving the practitioner wondering if they have missed something in the assessment.

Paul recalled an incident which had occurred when he was a trainee. A patient in an inpatient setting had been allowed out on leave over the Christmas period, and had subsequently died of an overdose, due to concealing certain aspects of her suicidal ideation from clinicians. On reflection Paul said…

> "*I think it would have been inhumane to deny somebody to go out on leave if you didn't see that there was any particular risk, and you can't have a situation where you are over restrictive, because that can be abusive of patients".*

A decision had been made and a sad outcome had arisen, and yet Paul felt that restrictive practice -where there was not valid evidence- would not have been in the patient's best interest.

Paul did not think it was always in the patient's best interest to be hospitalised. As a junior doctor he recalled carrying out perhaps eight overdose assessments a day, and yet he would usually only admit perhaps two patients onto the ward. Paul recalled one Consultant he had worked with who did a ward round every day, and she would discharge some patients who had been admitted overnight, particularly those with emotionally unstable personality disorders. In her opinion, hospital admission did not benefit them, and she felt it could be harmful. Paul thought admission to wards is not always beneficial, because patients can pick up behaviours from other patients that actually increase their risk.

Paul thought it was important to manage people's anxieties, but also to provide appropriate support. Whilst he did not think hospital admission was always the right answer if the patient was going to be cared for at home, it was essential to consider their social situation and to make a judgement. It may not be satisfactory to place an unfair burden of care on families who do not have the resources to cope with the patient.

Emotional health

Paul thought the nature of the work made it essential that practitioners maintained good levels of emotional health. He thought the demands of working with severe mental health issues and suicide, could lead practitioners to become overwhelmed or burned out, and this could make them unfit to work. He wondered whether a practitioner's objectivity and judgement could be compromised, or whether they could be meeting their own needs rather than the patient.

Throughout Paul's narrative he highlighted the need for practitioners to seek support from colleagues. He had experienced value from sharing, and he had also been a "sounding board" for his colleagues. He felt that particularly when a patient has killed themselves, personal feelings and responses need to be examined with a trusted colleague.

Paul made the observation that he had seen a high turnover of staff in some teams, due to the pressure and stress that they faced. He wondered about the relentless demands they endured, and if time had been provided for them to recover. Paul also expressed concerns about the way organisations react when someone kills themselves, and the blame culture which can prevail.

Gemma's Story

6.7 Introduction to Gemma

Gemma had worked as support worker on a psychiatric inpatient ward for four years, and had recently transferred to a new setting. In her role as a support worker Gemma had helped patients with daily living, such as taking them out for walks, helping them tidy their rooms, showing them how to top up their phones with credit, along with observations and supporting the nurses. The patients had severe mental health disorders such as depression

or paranoid schizophrenia, and many presented with significant self-harm and suicidal behaviour.

I met with Gemma at her new place of work, where she had booked an office in which we could talk. Prior to the interview Gemma had been a little nervous and had emailed me asking for an idea of the questions I might ask her.

6.7.1 Structure of Gemma's Story

Gemma started her story by outlining her new role, prior to moving on to describe her previous job as a support worker. Some aspects of the support worker role were mundane, whilst others were significantly more challenging. An example Gemma gave was being asked to read patients' suicide notes which they had written to their family.

> *"It's really weird, you just have to get used to it, it's horrible and you don't know what to say… so you do tend to just listen… you just listen, but there is that feeling of you just don't know what to say for the best".*

The central part of Gemma's account focused on the suicide of one patient Gemma felt had not received the right support for his needs.

> *"It is so difficult because there just wasn't a service for him and even now with any counselling there are just such long waiting lists for everything".*

This was followed by Gemma's observations on the support she received from colleagues, before sharing her final thoughts on the benefits of her new job.

6.7.2 Co-construction of the Story

Gemma was unsure of how to begin her account, and as we were in her new work environment I used this as a starting point. Comparisons were made about the difference in pace and lack of aggression in the new job. I was mindful of Gemma's hesitation, wanting her to feel at ease, and that there was not a right or wrong way to respond to my questions. I purposely took a more informal manner along with a gentle tone.

When I sensed Gemma was ready, I used one of her comments in the survey data to invite her to speak of her experiences of working with suicidal patients.

Our turn taking was more frequent than I had encountered in some of the previous interviews. I noticed that when Gemma hesitated I had a keen sense of wanting to rescue her. I was aware of a concern rising within me related to the graphic images Gemma described, and the possible trauma she may have experienced.

When Gemma spoke of her patient who had killed himself, and her concerns that he did not have the help he really needed, I was thinking the same in relation to Gemma. As she spoke of how he had been let down by the system, I wondered if Gemma had been let down by her organisation.

6.7.3 Voices in the Story

There seemed to be a voice of helplessness in the background of Gemma's story. Whilst she worked hard and did all she could to support her patients, there was a vulnerability about her. It was as if Gemma was swimming against a very strong current, and at times it seemed as if she was drowning.

6.7.4 Themes in the Story

Overwhelming

Gemma spoke of times when due to staff busyness she was very much on her own. Gemma reflected that she was "…*literally running around", "It was quite hectic*" and "*overwhelming*". Gemma mentioned how patients had threatened to rape or kill her.

Gemma outlined one particular patient who had stayed on the ward several times. Prior to his last admission, he had made a very serious attempt on his life, and spent a few months on the ward before being discharged. However, two weeks later he killed himself.

> *"It's not like you're in the office for 7 ½ hours, you are just out there with them all of the time….so you get quite close in a way".*

When I asked Gemma what her thoughts and feelings were when she heard of his death, she replied,

> *"I just burst into tears straight away …I was gutted because he was such a nice person".*

Gemma went on to describe how before he was discharged, he had wrapped up boxes as Christmas presents to make the ward festive, and put them under the Christmas tree. Gemma was moved as she recalled…

> *"I kept looking at them (the wrapped boxes) and thinking he wasn't here anymore…yeah, it was just really sad".*

Gemma reflected that her way of coping was to drink:

> "*I would have gone home and had a glass of wine straight away. I don't do that anymore, every sort of time on the ward- you know if it's just really stressful or really busy someone would go buy cakes or something…I've lost a stone since I was working there*".

Gemma gave an example of doing a routine ward check one evening:

> "*I opened the door, saw that she was there, closed it again, ticked her off…I obviously hadn't caught up with processing the image in my mind, so I opened the door again… and she was quite low, and she had this ligature around her neck, so I pulled my alarm…all the nurses came running and I just shouted at them get oxygen…I just screamed 'Get oxygen, get oxygen' so they all went off to get that, and I just literally ran through the ward crying to the staff room because of the shock of it".*

Following this event Gemma had vivid nightmares for several weeks.

Gemma also spoke of a patient who would self-harm quite badly, and sometimes Gemma would find her naked on her bed having cut herself all over like a chequered board.

Gemma came to a point of recognising that she felt physically exhausted by her work, and would literally be 'limping' home at the end of a shift. There was also an awareness of losing her patience.

> *"You get hardened to some stuff, and then you just…think…I just felt like getting more and more angry …then you're just sort of worn out...you lose that sense of job satisfaction".*

Gemma reflected on when she started her job as a support worker, and the lack of training and preparation for the role. At the job interview she knew it would be a challenge, but nothing could have prepared her for what she was about to face.

Support

Gemma explained how the nurses would invite her out for a cigarette, even though she did not smoke. They would then reassure her, and emphasise that the struggles on the ward were part of the job. When I asked about supervision support Gemma said:

> "*The nurses did take you to one side and have a cake, what else is there really....there was no formal support".*

Gemma told me that management was trying to bring in supervision. This concerned Gemma because she thought that the person to whom you were allocated may not be the person you would choose, and so there was the possibility you would not get on. Gemma said:

> "*I'm quite good at sorting it out myself-by the time I had got to supervision, I would have sorted it out myself really, but at the time I think I had supervision twice in three years".*

Gemma had recently been having acupuncture, and when I enquired for what reason she replied it was for anxiety.

> "*Yeah, it's funny because I have been having acupuncture since January, and it's weird because your acupuncturist asks you about everything, tiny things… and I was*

saying to her 'It's weird talking to you and you actually caring about these little things because…you know, you go to your Doctor……they don't care about…. they just care about that one thing you have gone to talk to them about', so I was saying to her it was bizarre you actually caring how I really am …even the little things".

Acupuncture positions needles in the body which are reported to result in the body producing pain-relieving substances. I felt sad that Gemma had resorted to this intervention to relieve her pain. Gemma had endured so much, and I was disappointed that a young person had not been bettered prepared or supported for such a challenging role.

Julie's Story

6.8 Introduction to Julie

I met Julie at her place of work: Julie was presently working in a non-clinical role within the NHS but had previously been a Mental Health Nurse. In the past Julie had worked with a Child and Adolescent Mental Health Team, and specialised in supporting young people who were substance dependent.

Julie had been an advocate for those who were marginalised, on the fringes of society, the forgotten and misunderstood. Julie had invested her time and energy into helping young people, and on occasions this had had an impact on her at a personal level.

6.8.1 Structure of Julie's Story

Julie spoke predominantly about three young women that she had worked with, one who took her own life and two who, despite the challenges of their circumstances, managed to keep on living. Julie then moved on to speak more personally about the impact the work had on her own life and family.

6.8.2 Co-construction of the Story

There was a warmth and kindness about Julie which made speaking together very easy. The conversation flowed naturally, and she was clearly passionate about her work with young

people. In contrast to her warmth and kindness there was also a feisty side to Julie which conveyed the battles she had had to engage in over the years.

The stories she told were very moving, and midway through the interview I asked her "*What was going on in your life when you were working with some of these young people that were really challenging*"? This question allowed Julie to speak about her husband, children and the pain they had experienced. Julie was taken back by her emotions, and surprised about speaking so freely in relation to her family.

At the end of the interview I asked Julie if there was anything she wanted to add, and she responded by saying how she had been looking forward to the interview, and that she had wanted to help me in my research. Julie added that it had been good to remember the work she had done, and to recall the young people.

> *"I'm glad that I have met some of these young people and glad that I have been part of their life… and glad that they are able to use the skills that we taught them".*

6.8.3 Voices in the Story

The voice of pain was woven through Julie's story, not just in the accounts of her clients but also her own emotional pain.

There was also the voice of sacrifice of someone who had genuinely fought battles for the benefit of others, despite the consequences to themselves.

6.8.4 Themes in the Story

Struggle

Julie described the difficult piece of work she had done with a young woman over a period of about a year. There were many complicating factors in the client's life which elevated her risk, and although Julie struggled with the system in order to get the support that her client needed, Julie's efforts were to no avail. Those with the power to take action did not listen to

Julie's plea. Sadly, the client took a number of overdoses, and on her last day at secondary school took her final overdose and ended her life.

Julie struggled to recall…

> *"I can't remember now, erm…yeah… I can't remember what that was about now…. and it is hideous that she has become so vague in my memory, I remember the start and the end".*

Julie went on to recall being in her office when her manager read out a couple of names of young people who had taken overdoses. When Julie heard the girl's name she cried out "*She is mine*", and there was a dreadful image in Julie's mind of what the young girl must have gone through.

In the days which followed Julie felt guilt and sadness followed by anger. The anger was directed at the supposed system of support for young people, which had let her client down so badly. Julie said:

> "*They ignore kids that take drugs and kids who are in care, or under the eye of social care -they take drugs and it's like 'Well that's what they do'…. it's like they are promiscuous, they're not, and they're kids*".

Following her client's suicide, the psychiatrist who had been supervising Julie went to visit her, as Julie had been experiencing difficulties sleeping. The investigation process was a challenging time for Julie:

> "*You're just waiting, and that is worrying, you're just waiting for that… you know you are going to get blamed for something …I hadn't experienced working within a culture that you would describe as one that was filled with blame".*

Julie recalled another young woman who self-harmed in order to regulate and to self-punish.

> "*When I met her she was 16, and she had the most hideous life I had ever heard of … I'd worked with adult drug users for years and years and years, and they generally*

had hideous lives, but I had never heard of a life that this young woman had experienced".

The client presented herself in such a way that sessions were very challenging for Julie, leaving Julie feeling rejected and repulsed. Julie addressed this:

> "*I said to her you know it really demotivates me when you speak to me like that*", *and I wondered if at least while we were together, knowing that I was never intentionally going to harm her, that she could try and not hiss, because it made me want to not come to the appointment …and it made me want to arrive late and finish early, and things like that"*.

The sessions from that point began to change for the better and a successful piece of work was completed.

Personal toll

At the time that Julie was working with young people there had also been an incident with one of her own children, which Julie described as "*hideous*", "*difficult* " and "*the hardest*". As Julie thought back to that time in her life she said:

> "*I think I was probably quite depressed after that*".

In addition, Julie's partner was in similar work to Julie, and he was feeling burned out and unsupported, resulting in him changing career path.

Julie had not disclosed how she had been feeling at that time, due to her concerns about perceived stigma. Julie reflected,

> *"Those were tense times and I wouldn't really like to go back there".*

Andrea's Story

6.9 Introduction to Andrea

Andrea worked as a Project Worker at a Drug and Alcohol agency, and was also a qualified counsellor. In her role at the Drug and Alcohol agency Andrea had a number of clients' die over the years -some from natural causes, others from accidental overdoses and one from

suicide. This particular lady had stayed on Andrea's mind. Andrea chose to meet me at my home for the interview.

Andrea had previously facilitated a group at the Drug and Alcohol agency which the client had attended, but when the client's project worker left the agency, Andrea was appointed as the new project worker. Andrea described the client as 'fighting to stay sober', but it was a real battle because part of her wanted to drink in order to "block it all out".

The client had had a child die some years previously, and although she was not to blame for the child's death, the client could not forgive herself and would constantly need to punish herself; this torment resulted in depression and drinking. The client had since been motivated to remain sober, as she wanted to gain help from mental health services in order to rebuild her life.

Andrea described her client as,

> "*…a lovely lady and very brave in lots of ways to still be there and hanging on in there.*"

A referral to mental health services had been made, and the client had had three assessments, but was told that she would have to self-refer to a particular group. The client was at the point of referring herself when the battle became too much, and she killed herself.

6.9.1 Structure of Andrea's Story

Andrea started by describing the context in which she worked, before moving on to speak about two clients that she had supported. The first client took a fatal overdose, and the second client- who Andrea was presently working with -continued to battle with excessive drinking. The final part of Andrea's story was her own story of addiction.

6.9.2 Voices in the Story

The voice of survival came through as Andrea spoke of her own fight with addiction, and how she had clung on to the edges of life. Andrea had also survived the death of her partner and the suicide of her client.

6.9.3 Themes in the Story

Business as usual

Andrea was informed by her manager that her client had killed herself, and Andrea recalled that the message was given in a "blunt" manner…

> "*…almost saying it in passing… as if I'm then just going to go back and sit at my desk and say okay, fine thank you".*

This caused Andrea to feel angry towards her manager, and she recalled similar occasions when she had been informed of difficult incidents in the same manner. It was as if Andrea's record keeping had to be up to date in case an investigation took place, and this was more important than anything else.

Andrea did carry on with her work that day, but it was not business as usual. Below is an extract describing how Andrea felt after she had received the news of her client's suicide.

> Andrea: "*I did, I did carry on working but it was hanging over me".*
>
> Susan: "*When you say hanging over you, what does that mean"?*
>
> Andrea: "*It was with me I suppose… I was feeling quite low myself really and I suppose I was trying to take it in… but yeah I did feel quite dark myself, really, having this news feeling like it was just hanging on me, around me."*
>
> Susan: "*What support did you have around you"?*
>
> Andrea: "*Nothing in the agency really, nothing… erm… I could, if I wanted to I suppose have said to a line manager 'Can I talk to you about this?', but the way that they sort of deliver the news… you know, the way I felt the news was delivered to*

me…I didn't particularly want to go and talk to the person that had actually said it like that because….I think that I would've felt that me or the client were not being given the kind of…the proper space that I think me or the client would've deserved. So actually I wouldn't have wanted to do that so I didn't. I can't remember now exactly how long it would have been until I had my own supervision because I have always had outside supervision…I pay for and source it myself- that's nothing to do with them, and I know that I took it there and spoke about the client there…that would have been the only place really that I could safely do that, and do that in an environment I would have felt it could be talked about and listened to in the way that I would have wanted it to be".

Andrea valued her supervision as it provided her with something that the agency could not give.

Andrea believed having the time, space and the care of another human being allowed her to feel supported and to attempt to process her thoughts and feelings. In contrast, the line management Andrea at the agency had left her thinking that her clients were not always respected or cared for;

"*In the agency sometimes people can become numbers".*

Supervision enabled Andrea to speak of her clients as people, in a caring and compassionate way that was not always possible within the busy agency setting.

As Andrea reflected further she said,

"I think the higher up we go in any organisation…. I think that the caring kind of stops and it does turn into stats and money, which is sad".

Marked by the loss

Andrea said:

"*I will always have that little question in my head… did I do everything that I could've done?".*

As she spoke about this Andrea did not think this questioning would ever

leave her completely. Andrea believed that, because the loss of a life was so significant to her, it meant that it could not be shaken off in the way that some client events or disclosures can. Andrea reflected that the remembering could come and go for a brief time, but would always return when triggered by the memory of her clients and their personal battles.

Joan's Story

6.10 Introduction to Joan

Joan worked as a psychotherapist at a secondary care level within the NHS. A significant number of clients' Joan worked with presented as complex, and had personality difficulties. Joan had many years of delivering therapeutic work on a one to one basis and in a group context. I arranged to meet Joan at her office.

6.10.1 Structure and Co-construction of Joan's Story

Joan commenced her account by mentioning a suicide which had occurred more than twenty years ago. However, Joan quickly responded "*but it was a long time ago*" and changed the focus on to a lady that she was presently working with who continually threatened suicide, whom she referred to as Mary (not her real name). During her account of Mary, Joan used powerful language to describe the client and the impact that Mary had on the people around her.

Joan then went on to speak of many personal losses that she herself had experienced, of close friends and family members who had died at young ages.

> "*I suppose my experience of being around death is with people who didn't want to go, who desperately clung to life".*

This seemed a huge contrast to some of the clients Joan spoke of who actively engaged in suicidal behaviour, or as with Mary threatened suicide on a regular basis.

At one point Joan said:

"*You have just made me remember, I had slightly lost sight of this…*"

… and Joan then went on to outline an assessment she had done with a young client who had attempted suicide on several occasions, whom she had been particularly concerned about.

Joan then came back to the story which she had started and abruptly stopped, of a lady who had taped herself during her suicide and requested that Joan be given the recording. Joan considered her personal response to speaking to me about this incident:

> *"I found myself getting very hot when I was talking about the woman who committed suicide twenty or twenty five years ago… which is interesting… so something was going on, and that was a long time ago".*

6.10.2 Themes in the Story

Stuck

Joan spoke of Mary and described how she would often look "stricken". In a recent session Joan recalled saying to Mary

> "*…that she looked like she was in shock, as if somebody had kind of whacked her with a mallet*".

Mary had lost all the colour in her face…

> "*…she looked absolutely distraught, like she was almost in a kind of trance".*

Joan went on to describe the sense of "*stuckness*" that Mary can bring to sessions.

Joan was aware that she spent a considerable time reading about Mary's presenting issues, and even at home …

> "*…trying to apply theory to practice"; "I found myself ordering some books from the library to see if I can throw a bit of fresh thinking on her so there is something, I don't know".*

Joan reflected further on the amount of time spent thinking about Mary,

"*…so she has me, more than some people*".

Both the client and Joan seemed stuck-for the client she was stuck in a kind of trance, and for Joan she had been hooked into thinking about Mary. Joan pondered on this a while, and then said:

"I suppose for me there is a kind of professional…not pride but part of me wants to be able to make more sense of what her struggles are…she won't let me in so I am kind of trying to peer over the wall".

Fight for life

Joan recalled an 18 year old woman who had made several suicide attempts, and when Joan met with her "*this young girl looked, kind of almost catatonic*". There was no change in her presentation or desire to not persist with killing herself, so she was hospitalised.
Joan had a strong sense of doing what she could to fight for the client to remain alive, and not die prematurely.

"*I just thought, you know, she is 18, we have to keep her alive so that when she is 22 or 32, she can look back and say thank goodness I didn't go through with it because you know, here I am having a life, whatever that looks like… backpacking, university, marriage, who knows… but I just thought, we can't allow it".*

Joan had not been able to prevent close family and friends from dying, but she did everything in her power to not allow this client to die.

Horrified

Early on in her career Joan recalled a weekend workshop that she had led, and several weeks later Joan was contacted by the police because one of the workshop attendees had killed herself, and left Joan's name, and the name of the workshop, as she wanted Joan to be involved in sorting out her belongings.

"I was hugely shocked, really shocked, I felt spooked as well… each suicide is different, but the fact that my name had become entwined in this woman's mind".

Joan reflected on the briefness of their encounter;

> "*I mean I'd spent 8 hours of my life with her, and suddenly my name was on a note in her car, saying could I listen to this… I mean I was offered a tape to listen to that she had made as she killed herself….no I did not want to listen to it, of course not, I would have been horrified… so I think there was something… I mean looking back, I think there was a lot of hostility in it, even though it seemed as though I was being singled out to be the one who had understood- actually I think it was a horrifically hostile thing to do to somebody, you know, I was a stranger but I think this was the stuff that belonged to her family that was coming out sideways".*

Karen's Story

6.11 Introduction to Karen

Karen was a psychotherapist working closely with an NHS Community Mental Health Team. In addition, Karen worked privately as a therapist, supervisor and trainer. Karen had experienced one of her clients kill themselves sometime after the completion of treatment. Karen had two supervisees who had experienced client suicide, and this was something which had also impacted upon Karen. I met with Karen at her place of work.

When speaking of her own client who killed herself, Karen recalled:

> "*It was so 'on the table'- it was ever present, ever, ever present -she always said she would die, and it was just a matter of when".*

The client had been a severe self-harmer who had required hospitalisation on many occasions, and Karen had worked closely with her in phases, according to when the Mental Health Team thought she required support. Karen described the inevitability of the client's death, and that she was not surprised when it did happen. However, in contrast Karen also said "*I always travelled hopefully*".

6.11.1 Structure and Co-construction of Karen's Story

Karen started her story by speaking of her own client's suicide, and the impact it had had on her, and then she went on to speak of her work as a supervisor. Karen spoke of her concerns about the NHS, and the stress which staff were put under by management. As a Manager in the NHS I found Karen's strong opinions challenging and compelling. I was interested in Karen's insight and observations, and although her comments were at times damming, her concerns were born out of a desire for clients' and staff to be well cared for.

At the end of the interview I asked Karen how she was feeling, and she replied,

> "*I found it quite sad actually, not towards you, but just the materials, yeah I feel quite sad actually because I haven't visited it for quite a long time -but it has not been unpleasant… but it is just talking about stuff that is sad, but you haven't made…it's been very easy to talk to you and it is very interesting".*

While Karen felt sad, I felt a renewed motivation to review how my own team were managing their stress, and ensure that client care was our priority.

6.11.2 Themes in the Story

The Cost

Here is an extract from Karen's story, and as with Diane's story I have again used a stanza style to highlight the narrative:

Well, I kind of veer between kind of hopelessness and anger

because it….

and of course it pushes your nose right up against your inadequacies as a practitioner,

but of course we all have to…

it's something about bearing, that

it is your own kind of frailty and inadequacies

and just normal, ordinary limitations of being a person

that you can't, if somebody really wants to do that…

you know I kind of held her in mind

and did my best and got lots of Supervision,

but was very aware that she was in a terrible place most of the time.

Yeah, you're just faced with your ordinariness really,

and managing that level of despair

because she was very, very despairing

and it was very, very hard to meet and do much about that actually…

a lot of it was just about sitting there and bearing that.

I found Karen's words very moving. There was a powerful sense of Karen staying with the client's despair and bearing it. As Karen spoke of her own and the client's frailty, she also recounted:

> *"I'm like most, well a lot of people that go into this work …I'm also very porous, so there is a level at which it disturbs me which is very difficult, and I think we have to be disturbed by our patients".*

Karen thought this collaborative and transparent way of working helps practitioners to 'Use their heart and get close to their patients'. Karen was also mindful that this intensive connection between practitioner and client could come at a cost to the practitioner, and for some even burnout. Karen acknowledged that in the small team in which she worked colleagues were currently off sick, and at least one of those with stress.

Relationship and Communication

Although Karen was not working with the client at the time of her suicide, she was grateful for the team approach. Karen felt involved and informed, and they worked through the process as a team together. Karen recalled the client's CPN phoning her at home to let her know of the death. Although it was not a working day, Karen valued being updated in this way rather than arriving at work the following week to be faced with the news.

In her role as a supervisor Karen described being "*one step removed*". Karen spoke of how she supported her supervisees, but when it came to it they had to endure the investigation process, having to speak about their decision making and having their clinical notes scrutinized.

One of Karen's supervisees was a trainee who had had a considerable amount of time off due to sickness. Despite Karen's best efforts to support her, the supervisee had not been able to complete their clinical placement, or to gain their qualification. Karen wondered whether the circumstances of their client's suicide had been the cause of this difficult ending for the supervisee.

Following a client's death of another supervisee, they had received a debriefing session with a senior clinician, who provided an opportunity to talk about what had happened, and how they felt. Karen appreciated the kindly way in which the clinician had led the session.

Karen made an observation regarding her team, that fewer clinicians were picking up the phone to speak to other professionals.

> *"I suggested to someone… you know pick up the phone and talk to the psychiatrist, and the response was, ''…but I have done it all on the computer".*

Karen believed this attitude was not in the best interest of the client, and lacked the human relationship of contact with colleagues.

Health Service Cynicism

Karen was cynical about systems which had been put in place to reduce client suicide within the NHS, and believed that they were in fact taking staff away from the clients, thus possibly increasing risk;

> *"I would love to see the figures…show me that this brings suicide rates down and it increases the safety of the patients".*

Karen was concerned about the amount of time staff spent at their computers, and the level of recording which they were expected to complete. Karen thought this was due to organisational anxiety.

Karen reflected on something she had heard in the media about research into work- related stress. The research had suggested that those at the top of management structures pass stress down to those at the bottom, and it is the lower tier of staff who carry the stress rather than the managers. Karen went onto talk about people churn:

> "*They get people in, they work them until they are dead on their feet, they get rid of them and get a new bunch of people in… maybe that is what the Health Service wants to do- it's a business model, but I don't think you will get the best practice from people doing that. But you take youngish people and overload them for a few years, get rid of them and then move on to the next lot…"*

Karen acknowledged that management was not an easy role;

> "*I don't know, I just wouldn't want to be in charge because I think these are really difficult roles…I think people need to be in a caring organisation where they are supported, and they don't have to see too many patients… which is what it used to be like, you know, back in the day people would have time to think- but the whole thing seems to be spiralling out of control …but as I say, am I just getting old and sucked into the Health Service cynicism?".*

6.12 Summary

Through the process of narrative analysis, themes have emerged demonstrating the complexity and challenge which practitioners face when working with suicidal clients. This challenge is felt at both a personal and professional level, and it would seem that following client suicide, it is not as easy as with other client presentations to compartmentalise the personal and professional sides of the self.

For some practitioners the suicide of their client had not been foreseen, and yet with hindsight the signs had been present. Its impact caused considerable self-questioning, and raises questions around the power of transference and countertransference responses, the need for self-awareness and reflectivity, along with the use and quality of clinical supervision.

Whilst some practitioners were able to work in partnership with the GP, leading to greater client safety and strengthened collegial relationships, others were faced with defence, as in the case of Diane. This contributed to practitioners experiencing further self-questioning and blame.

In some incidences practitioners appeared unable to recognise their own personal needs, resulting in stress, low mood and anxiety, whilst in others, practitioners had concerns around the impact of client suicide on their reputation.

Boundaries have been blurred and ethics have on occasions come under scrutiny: practitioners' have questioned the support they received, along with the organisational ethics and values of their employers. However, other practitioners coped following the death of their client due to the support they had gained from their colleagues and organisations.

Complex client presentations have led to practitioners having blind spots, acting differently, struggling and 'feeling stuck' during the work. Some practitioners have fought for the life of

their client, whilst others were unable to save the client. Despite all of these difficulties, practitioners exhibited survival, resilience and determination.

I have outlined a summary of the individual stories of my participants, and endeavoured to do this in a sensitive yet congruent manner. The personal toll of writing this chapter has been particularly challenging, as I have immersed myself once again in the stories. I have experienced tiredness, and a desire to distance myself from what I have read and heard, yet at the same time fought to stay with participants' narratives. I am aware that some of the themes which arose for the participants are also mirrored in my own experience of being with them on this journey.

In the next chapter I will show my findings from the whole interview data set using thematic analysis.

Chapter Seven: Findings from Phase Two Interviews using Thematic Analysis

In this chapter, I will outline my findings from the thematic analysis used to analyse the eleven interview transcripts, following the completion of the narrative analysis.

To examine the themes from the individual interviews I followed the same thematic analysis method used previously, as outlined in chapter three and four in relation to Braun and Clark (2006):

Stage 1: familiarising yourself with your data

Stage 2: generating initial codes

Stage 3: searching for themes

Stage 4: reviewing themes

Stage 5: defining and naming themes

Stage 6: producing the report

The stages of thematic content for the interviews can be found in Appendix N.

As I began this final stage of data analysis, I had my primary and secondary research questions at the forefront of my mind:

1. Working with suicidal clients: what are the effects on the practitioner?
2. What support do practitioners require when working with suicidal clients?
3. What are the training needs of practitioners working with suicidal clients?

The codes and thoughts from the data set for stage 4 of the thematic analysis process are represented in Table 18:

Table 18: Phase Two Thematic Analysis

Code Label	Theme Definition	Examples
Way they found out	Reaction to the news	"*I just need to let you know that your client died and almost says it in passing as if I'm then just going to go back and sit at my desk and say ok fine thank you*". (Andrea) "*My name was on a note in her car saying could I listen to this, I mean I was offered a tape to listen to that she had made as she killed herself….no I did not want to listen to it"*. (Joan)
Initial thoughts and feelings	Reaction to the news	"*I felt blown away*". (Joan) "*It was just really sad*". (Gemma) "*I felt such an overwhelming sense of helplessness*". (Gill)
Thoughts about the method used	Personal beliefs and anxieties	"She *had taken an overdose- after all her many attempts she took a fairly mundane…she was talking about jumping off the car park from on high, but in the end she took an overdose with a bottle of brandy or something*". (Stella)
Initial thoughts and feelings	Personal beliefs and anxieties	"*I wasn't surprised when it happened you know, but I don't think I ever thought, yeah that is going to happen,-I think I*

		always travelled hopefully" (Karen). "*It is quite a significant thing when your first client commits suicide; for me it was quite major*". (Sonia)
Sense of responsibility	Personal beliefs and anxieties	"*I should've done so much more for her*". (Julie) "*So I try to remain objective and tell myself that people like me have to make decisions because if we didn't who would?"* (Paul)
Personal identification	Personal beliefs and anxieties	"*I built up a relationship with her and she was a woman of a similar age to me, so I think I identified with her a lot -and so I think that was really hard*". (Sophie)
Supervisor	Relationships	"*I rang my supervisor when I got the letter… he was brilliant*". (Diane)
GP	Relationships	"*The GP, who was quite newly qualified and obviously for a GP… this was pretty horrific that it had happened to them, and wanting my support*". (Sonia)
Colleagues	Relationships	"*They would generally be around and just check you were alright before you went in, and you know a cup of tea when you came out, and things like that so it was quite supportive in that way*". (Julie)
Client's family	Relationships	"*His partner effectively had said to my*

		colleague, 'Can you let her know?', and it felt as though I had been slightly left out of something". (Gill)
Learning and enlightenment	Resilience	"*I don't panic in a crisis… I mean I had a burglar here once and I got up and talked to him- I am amazed sometimes what you can do in a crisis*". (Stella) ''*I think the fact that I've suffered significant losses and death of people myself in the past kind of prepared me for the fact that it happens and some of the feelings you get when it happens".* (Andrea)
Changed by the work	Resilience	"*I thought… it is not going to stop me from being a counsellor…it's hopefully going to make me a better counsellor*". (Diane) "*When I qualified, you see, it was either sink or swim- you either got on with it or you went under, so it developed a sort of resilience and self-reliance, which is helpful*". (Paul)
Toxic	Environment	"*Well, I don't know, I've certainly known several people go on long term sick, retire early that sort of stuff*". (Karen) "*I think that breeds a kind of anxiety so maybe…you have to be a bit guarded when you respond to things…I think that culture can develop and I think that's quite*

		negative really". (Sophie) *"I have noticed that there is a high turnover of staff".* (Paul)
Supportive	Environment	"*I think the whole thing about working in a Team is absolutely crucial*". (Joan) "*…we were all very encouraged to talk about what we wanted very freely…erm…so actually yeah, it felt very, very supported at work*". (Sonia)

Once this stage had been completed, I formulated a thematic map as illustrated in figure 11 which reflects the overall meaning of the data set.

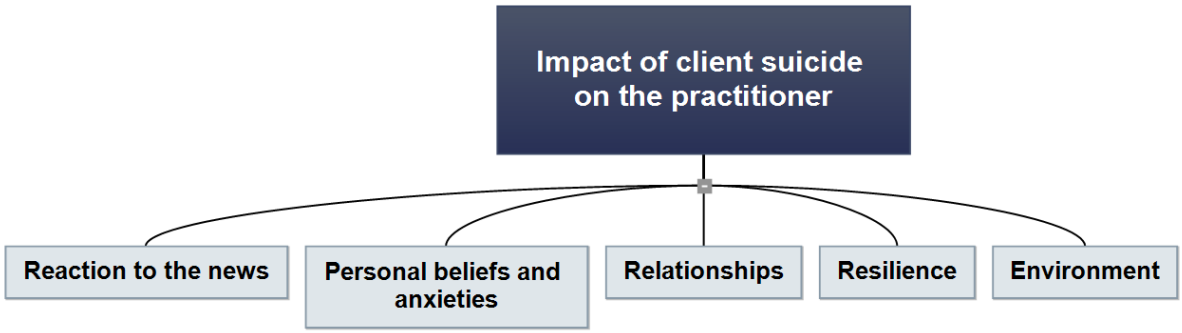

Figure 11: Thematic Map: Impact on Practitioner

I will now provide a definition for each of the themes, and explain the story that the theme is portraying.

7.1 Reaction to the News

We receive news every day in many forms- from a conversation with a friend, to seeing an event occurring on television. News can also have varying levels of importance: an example could be a neighbour telling us that they have bought a puppy, which on the surface seems an inconsequential piece of news. However there are factors which could escalate the importance of the news, such as our relationship with the neighbour, the breed of the dog, our attitude to pet ownership and the implications that having a dog next door might have on us, to name just a few.

This theme encompassed a multitude of reactions which practitioners articulated, in relation to hearing about the suicide of their client. One factor was the medium by which they found out, such as on the telephone, face to face, via a post-it note or a letter from their client. Another consideration was the setting they were in when they received the news. For example, some were at home alone, whilst others were in an open plan office or at a team meeting, and practitioners had very individual responses to the setting they were in. One practitioner was grateful to be alone in her office, so that she could begin to process the news, whereas another person felt frantic at being alone. There were polarities for those who heard the news whilst in the presence of colleagues; some spoke favourably about having support immediately from team members, whilst others thought the public context was exposing, causing them to feel vulnerable.

> *"One of the Nurses told me in the staff room…I just burst into tears straight away, I can't remember if it was before or after …we had another patient that killed himself and he was found in a river. I think it was two weeks after him…I can't really remember which way round it was now but we heard about both of them really close together and it was all a bit of a shock". (Gemma)*

The timing of receiving the news also played a part for the practitioners. Some practitioners spoke of receiving the news in between client sessions, or as they were about to go into a meeting or to deliver supervision or training. Practitioners indicated that they carried on with their work- related duties, but the quality of their thinking and their emotional availability may have been impaired.

"I remember walking around the kitchen and saying to the dog, I can't believe it, he couldn't have… I can't believe it, not really knowing what to do with myself. I mean, what can you do after that? I can't remember if I had clients… I quite often have late afternoon clients but I can't remember. I think I probably did- but I would have been able to cut off from it for that- and again I think the phrase in my head, probably for 24hrs or so was 'I can't believe it, he can't have, surely he can't have, it can't be true, really for him'… the wasted life". (Diane)

"I remember it because I was training that day- doing a whole day's training- and I can remember talking to the co-trainer, and she was like… 'Do not tell them, get in there and just do your stuff'… you know… which was good advice actually because I was a bit all over the place.''(Karen)

Practitioners highlighted that their relationship with the person who informed them also had an influence on their reaction, along with the manner in which the message was conveyed. This was apparent in the account of Joan who was visited by the police when her client killed herself, whereas Diane learnt from her client via a personalised letter, stating that by the time she read the letter he would no longer be alive.

The stage of the relationship with the client proved to be another component of this theme. For example, Stella recalled that the suicide of Claire had had a lesser impact on her due to the briefness of their relationship, and also because the clinical work had been some years ago: Stella indicated that this had provided a distancing. However, those who had been working with their clients when they killed themselves, were impacted more acutely by the news.

There were some particularly powerful emotional reactions from practitioners, reporting that they experienced, shock, horror, sadness, anger, guilt, helplessness and fear on hearing the news.

The findings from this theme provide evidence that however the news was shared or received, one constant feature throughout was that the content of the news was only partial, in that there was always missing information. It would seem that this apparent gap

in information caused a significant impact on practitioners, with some practitioners ruminating on what could have been done differently, or on what had been missed out.

As human beings, and also as professionals, we can sometimes live under the illusion that bad things only happen to other people. When a practitioner is confronted with a client suicide, it can be unexpected and devastating. It can rock the foundations of our thinking and cause us to wonder what else could happen to us, or to those we love and care for; our certainty in so many areas can become fragile. When faced with sudden death, the practitioner can question their own existence and mortality, causing them to feel extremely vulnerable.

7.2 Personal Beliefs and Anxieties

This theme demonstrates how the philosophical, epistemological and theoretical view point of the practitioner shapes the way they work, and how they respond to the suicide of their client.

Some practitioners spoke of the 'act' of suicide or of 'committing' suicide. Despite suicide not being classed as a criminal act in the UK for over fifty years, I was interested to notice how those working in mental health care still use terminology which implies a crime. Other practitioners referred to the 'aggressive' nature of suicide, indicating a hostile and deadly act to oneself, and a 'rejection' and 'vengeful' act on those left behind.

Joan spoke of her beliefs in this way:

"*Early death seems to be just full of waste anyway, but the idea of actually precipitating it… I always felt that suicide was a very rageful act. I mean some suicides more than others… but it has always struck me as a very hostile, very aggressive thing to do really, and it leaves such a legacy for the people left behind… it really seems such a punishing thing to do to people*".

Paul spoke of the impact that suicide can have on those left behind:

"*It's not like any other death as far as I can see… if someone dies of cancer it's obviously tragic but it's not the same… it's as if…I mean you can ask yourself why people did it, and*

you may not be able to say why…in some ways it's a sort of rejection, when people die of cancer or heart disease, it's not that they are rejecting life".

In contrast Stella held the view point of respecting client choice, and not actively intervening if their ideation increased. The consequence of this meant that when Stella's client killed herself she was able to say, "*I decided not to take any responsibility for someone else's decision".*

Karen, in her role as a supervisor, outlined an initial meeting with a potential supervisee who was a person- centred counsellor. It became clear to Karen that the counsellor was working with a high risk client, and that no assessment of risk had been carried out, "*Oh, God…it was so dangerous*". Karen only met once with the counsellor, who did not return for supervision. Clearly their frames of reference were very different: for one, an element of safe practice was rigorous risk assessment, while for the other this perhaps did not sit well with her theoretical orientation.

Practitioners also mentioned the importance of their clients' personal beliefs. Sonia provided evidence of this when she spoke of her client's belief that her husband was in heaven, and so for her to die meant that they would be together. This belief, held by her client, gave Sonia a degree of comfort.

Practitioners expressed opinions on the way in which their client killed themselves, with one practitioner saying:

"*He had taken an overdose- after all his many attempts he took a fairly mundane…he was talking about jumping off the car park from on high, but in the end he took an overdose with a bottle of brandy or something*".

The reference to the method being 'mundane' suggests that she thought an easier option had been taken. As already detailed in chapter six, Sonia spoke of how she would have expected the elderly client who hung herself to have used a "*gentler way*", and went on to suggest that "*every way of suicide is violent…I suppose the best form is taking tablets".*

Practitioner anxieties were expressed in relation to their part in the process. Karen questioned herself in the following way:

"*Oh, it's horrible, it is really horrible… it's awful and you know there is a sense of guilt and responsibility, and what could we have done differently".*

Similarly Julie said *"I should've done so much more for her".*

There was evidence of practitioners' negative belief systems being triggered, causing them to experience not just anxiety but self-doubt, and a sense of being a failure.

The personal beliefs of the practitioners appear to steer how they react to client suicide. All practitioners were affected, but this seemed in proportion to their own personal experiences, beliefs and interpretation of the event, and also to the level to which they felt involved or implicated. Some of the practitioners had very strong concerns about the suicide affecting their reputation, and most experienced significant self-analysis. It would seem that the suicide of a client could be interpreted as the fault of the practitioner-perhaps they had not done enough to save the client, or not understood the depth of despair, or seen the evident warning signs? Perhaps they had seen the signs but chosen not to act in response to them? Practitioners had their own internal dialogue about their part in this process, but also expressed concerns about how they would be judged by their peers, other clients, their profession, and society as a whole.

7.3 Relationships

Practitioners did not speak widely about their thoughts and feelings following client suicide: whether this was discretion and respect for client confidentiality, or a reflection of the practitioner being in a state of shock was not clear. Whilst the practitioner's relationship with their client was prominent in each of the accounts, every practitioner made reference to other relationships. These relationships- established at a personal and professional level- were described both positively and negatively.

Practitioners mentioned that following the client's suicide, they spoke about the event and its' implications with their partners or significant others. They also reported that it was not their usual practice to disclose details about their work, which could be as a result of the suicide impacting them at both a professional and personal level, thus causing the practitioner to have weaker boundaries. Practitioners seemed to need to be connected to

someone close to receive support, comfort and reassurance at a very vulnerable moment in their life.

> *"My husband is very supportive, so I did go home and tell him, I didn't go into too much detail but I did say what had happened and he was very helpful actually". (Gill)*

The place of the supervisor featured highly for most practitioners from a counselling or psychotherapy background. However, other professions seemed to place less value on this relationship; for those practitioners there was a greater need for self-sufficiency, and in some cases a lack of insight and ability to reflect on what had happened. This raises questions around the function and purpose of line management and supervision for those professions.

> *"I was in a supervision group at the time… I was much less experienced, younger, didn't have the support network of the NHS and I felt quite blown away by that, but my supervision group were fantastic. They were all women that I had known and had worked with for some years, and we kind of met and people picked me up and talked me through it". (Joan)*

GP's featured highly as being both helpful and unhelpful in relationship with the practitioners, with some GP's reacting in a defensive and even hostile manner, whilst others demonstrated support, collaboration and partnership. Practitioners- particularly in private practice- observed a need for clear referral pathways when their client went into crisis, and for good links with GPs. It would seem that for some practitioners, these relationships were not pre-established, and this caused considerable tension for them at the time of their client going into crisis.

Relationships with family members of the client were also viewed as helpful on occasions, for both parties, although on some occasions practitioners felt wounded by these encounters. Gill had the experience of a colleague passing a message on to her from the partner of her client. Not having direct contact with her client's partner caused Gill to feel on the edge of communication and "*cut off*".

Following a client suicide there are multiple relationships for the practitioner to negotiate, ranging from the clients family, work colleagues, supervisors, managers, investigators and other clients. Because the client is dead there may be many conversations which take place as a consequence, and it is important for the practitioner not to try to face these events by themselves. There is a need to allow trusted people in to support and aid the practitioner's resilience and self-care.

7.4 Resilience

For each of the practitioners, there was a demonstration of resilience as they continued on with their work despite the adversity caused by the suicide. They had relied on their inner resources and historic self-belief to aid them through a time of challenge, so that they were not overcome by their present difficulties. There was evidence of emotional intelligence, and an acceptance that emotions experienced in relation to the suicide of their client, were appropriate and proportionate. Although they had good and bad days as a result of their turbulent emotions and self-critical thinking, they were able to cope emotionally and manage any setbacks that occurred.

Practitioners provided useful reflection on the training they had and had not received to aid them to work with suicidal clients, or on what consequences to expect if their client died. Diane spoke of receiving excellent training, yet wondered whether practitioners sometimes think that suicide only happens to other people's clients and not to their own; she wondered whether this may lead to practitioners being unable to gauge the full extent of suicidal ideation through not enquiring sufficiently.

Sonia was unsure whether anything specific from her professional training had actually helped her, and put her courage instead down to her experience of working with suicidal clients, and having the support of a trusted supervisor. However, in her role of managing volunteer counsellors, Sonia had devised a comprehensive training programme, to ensure that the volunteers were well prepared for the challenges of working with suicidal clients. Sonia thought it was important for them to talk about client suicide, and for the counsellors to consider their personal beliefs in relation to suicide. Sonia stated that she would not recruit someone who considered suicide to be morally wrong, as it may affect their ability to

listen fully to the client. The training Sonia delivered was practical as well as theoretical, because she thought it was important for the counsellors to practise in a safe environment prior to having real conversations about suicide with clients.

Andrea struggled to recall any training on suicide from her counselling diploma or agency induction:

> *"I don't think I was given any preparation; I think probably in all honesty I had better preparation by my own life experiences of death and loss. I think the fact that I've suffered significant losses and death of people myself in the past, kind of prepared me for the fact that it happens… and some of the feelings you get when it happens". (Andrea)*

Gemma in her role as a support worker had not had any training to work with suicidal clients, but wondered whether having some preparation at the start of her employment would have been useful:

"*Before you start the job -or at the beginning- time with someone trained to talk about or run through your mind how would you feel if someone…killed themselves, how would you cope with it".*

Julie trained as a nurse twenty years ago, and did not have any preparation for working with suicidal clients. However, she put the key to surviving this work down to reflective practice and supervision.

Diane reflected on getting through the experience of a client suicide:

"I didn't think it was anything I did that was good or admirable that I did carry on, I just found that I could and then it made me feel well….the worst thing that could happen, has happened".

Other comments related to resilience included:

> *"I think, through this client, I feel a bit braver". (Sonia)*

"We can't predict everything and if we could we would be millionaires -so there is definitely an uncertainty in clinical practice that you can't overcome". (Paul)

"Hideous things happened to people and they are in the past, and we have to accept that is where they are. Well, we can choose… we don't have to do anything but we choose to accept that is where they are… and by doing that, we lessen the impact on our everyday life, whereby by continuingly fighting it, you are just bringing it into your daily life every day. So I love that… coupled with mindfulness they are my favourite things". (Julie)

"The fact that I could carry on working, and I could see suicidal people -and I did within a couple of weeks-I kind of knew either this was going to work or not, so I was really pleased to know I could. I think I would have been very sad if it had made me give up". (Diane)

In addition to their inner resources, practitioners exercised the ability to rely on external support which came in the form of family, friends and/or colleagues. Whether talking with a supervisor or friend, the ability to discuss and reflect allowed the practitioners to gain perspective in their situations. Rycroft (2005) suggests that confidence can be rebuilt if the practitioner has sufficient support over a period of time. Part of this support is the recognition that the impact of client suicide on the practitioner's confidence, is a normal response to such an experience, rather than pretending it is not, or hiding behind a false professional persona.

7.5 Environment

The environment or setting in which the practitioner was working proved to have both positive and negative elements. For some practitioners there were positive and negative aspects even within one setting.

Diane recognised that in private practice she was on her own, but the relationship she had with her supervisor enabled her not to feel isolated.

"I did ring XXX a week or two later and told her, she was very supportive and in a way I was saying I just wanted to let you know, I am ok, I've had supervision, I think my supervision is what counted and he was there for me". (Diane)

Gill also described her experience of private practice as being by herself, in contrast to her experience of a suicide which occurred when she worked in a secondary care setting, where Gill spoke of a shared responsibility.

Within private practice, it seemed that the environment caused some practitioners to feel isolated and alone. There was a greater need for these practitioners to reach out to colleagues and supervisors for support. However, within agencies and NHS settings the main positive factor experienced was team support, and opportunities to reflect together following a client suicide. The negative factors seemed to arise from management placing pressure on practitioners, resulting in stress, anxiety, ill health, absence from work, job changing or early retirement.

Andrea reflected on the atmosphere within her agency, where she felt that clients had become numbers, rather than real people with names. This depersonalisation caused Andrea some considerable concern, to the point where she paid for private supervision in order to discuss her clients. Andrea needed to treat her clients as people, and to consider them with care and compassion, which at times she felt was missing from her agency. Andrea thought that the reason for this dehumanising effect was due to the busyness of the agency.

A further negative factor within agencies and NHS settings, were the investigations which took place following a client suicide. Whilst practitioners could understand the place of investigations and the need for lessons to be learned, it also provoked their concern with regard to possible disciplinary consequences, and to working within a 'blame culture'.

Some practitioners observed that similar findings seemed to be highlighted following different investigations, usually related to the breakdown in communication between teams, or a lack of clarity in communication. This raised the question about whether recommendations from investigations were actively followed through and actioned by teams.

"Well you get worried, you get worried …about you know… should you have done more?... or what didn't you do?, were you in any way responsible ?... or you know… that sort of thing really …and in fact I ended up getting you know …after the hideousness… they said something like ..you know …'You tried hard". (Karen)

"I think part of the problem is the need for enquiries… we can understand why it has to be done, but it can be very unpleasant to go through things in detail, because we all have defence mechanisms -and they are there for a very good reason- and if you keep on picking away at them, you come to a situation when you feel very pressured". (Paul)

One comparison between settings, is that those in private practice work autonomously and can make their own choices, whereas those working for agencies or the NHS are governed by management structures, policies and procedures. The environment is thus determined by the ethos and values of these structures. A corporate culture of respect, mutual support, encouragement and honest reflection, and also where supervision is seen as being a crucial support mechanism, will breed wellbeing for both staff and clients. However, services led by those who do not value these principles will create toxic and hostile environments, leading to 'people churn'.

7.6 Summary

When practitioners discovered that their client had killed themselves, multiple reactions were evoked at a cognitive, emotional and behavioural level.

Cognitively, most practitioners had varying degrees of helpful self-examination and reflection on their clinical practice. However in contrast, some practitioners displayed high levels self-criticism, self-blame and feelings of personal failure.

From an emotional perspective, practitioners expressed shock, horror, sadness, anger, guilt, helplessness and fear. Whilst these emotions are all understandable initially following a client suicide, if they persist they could prove to become problematic for the individual practitioner.

Behaviourally, all participants carried on working- still seeing other clients, even on the day that they received the news of their client's suicide. Whilst this could demonstrate resilience, it could also be as a result of shock or denial.

The philosophical, epistemological and theoretical view point of the practitioner shaped the way in which they worked with the client, and also how they responded when their client killed themselves. Clearly, the death of a client during treatment can provoke strong emotions in the practitioner. However, unlike a death from natural causes, or even serious ill health, the suicide of a client can represent a rejection of life, which for health professionals who have been trained to fight for life, causes a dilemma. If the client is rejecting the help offered by the professionals involved in their care, perhaps there is also a rejection of the practitioner?

In some of the practitioner accounts, there was evidence of the suicidal struggle that their clients were facing. Although hindsight may offer a different perspective, it is possible that during the therapeutic relationship, practitioners were actually distancing themselves from the reality of their client's suicidal ideation.

The unique relationship between client and practitioner can cause the professional to question themselves, and the part they played in the death of the client. This would seem pertinent, with the question often asked, 'Had they done enough for their client?'.

When we experience the death of a friend, family member or colleague, it is perhaps natural to share that information with those with whom we are in relationship. However, it would seem that practitioners do not speak widely about their thoughts and feelings following client suicide. Yet this can be a time when many conversations need to take place at both a personal and professional level for the well-being of the practitioner.

Whilst there is a process to be navigated following a client suicide, and each person will progress through this at varying speeds, it would seem important that distress is not internalised. If thoughts and emotions are not expressed and considered at the time, it is possible that they could later manifest in anxiety and depression. Likewise, distress can be externalised and result in anger, but if channelled helpfully this could highlight organisational or system flaws and bring about positive change.

The perceived rejection that a practitioner may feel following a client suicide can be very damaging, causing them to doubt their professional competence. However maintaining healthy personal and professional relationships are an important factor in the healing process following client suicide, as they aid the development of resilience.

In this chapter I have outlined the findings from the eleven interview transcripts following thematic analysis, and highlighted the key themes which were evident in the practitioners' experiences following the suicide of their clients.

In the next chapter I will discuss all of the findings from my research, and the implications for practitioners in relation to supervision, training and management, as well as organisational policies and procedures.

Chapter Eight: Discussion

In this chapter I will discuss the key findings of this study in the light of my research question, and in relation to existing literature. The purpose of this study was to examine the experiences of practitioners when working with suicidal clients, and to explore the impact that it had on them if their client died through suicide. This was achieved by evaluating the data from phases one and two of my research using statistical, narrative and thematic analysis.

My research question was:

Working with suicidal clients: what are the effects on the practitioner?

In addition to the primary research question I was also interested in considering the following questions:

- What support do practitioners require when working with suicidal clients?
- What are the training needs of practitioners working with suicidal clients?

8.1 Overview

All of the practitioners who took part in this research study- whether their experience was working with clients who spoke of suicidal ideation, who made attempts to kill themselves or who died by suicide- expressed having been affected in various ways, and to varying degrees.

Whilst current literature has made a contribution to the understanding of suicide in general, there is far less literature related to the impact of client suicide on practitioners. Of the literature which did directly examine the effects of suicide on practitioners, there appeared to be a gap with regard to beneficial strategies to address these findings. One aim of my research has been to add to the present body of literature by highlighting not just the effects on practitioners, but what is necessary to prepare and support them.

The training workshops I have devised will make a practical difference by preparing practitioners to work with suicidal clients, and the proposed publication of narrative

accounts from the interviews, will enable those professionals bereaved by suicide to relate to the experiences of other practitioners. The products that I have developed will be examined in the next chapter.

In phases one and two, practitioners predominantly described themselves as counsellors or psychotherapists, although there were a sufficient number of other professions to provide a useful representation of relevant professionals, thus broadening the application of this research. In addition there was a clear cross section of work settings signified in the data, with the majority of suicides occurring within a secondary care setting.

8.2 The Effects on the Practitioner

8.2.1 Uncertainty and Decision Making

Practitioners whose clients presented as suicidal faced challenges related to their professional responsibility, such as maintaining the therapeutic relationship, holding appropriate boundaries and knowing when to keep or break confidentiality. This in turn caused an inner conflict for some practitioners with regard to making difficult decisions. Unlike some areas of clinical decision making, whether or not to breach confidentiality as part of responding to suicidal ideation is not always clearly defined as being a yes or no. This can cause the practitioner to feel in two minds about what action if any to implement.

In phase two practitioners spoke of a tension in relation to the speed with which a suicidal client can genuinely change their mind about acting on suicidal thoughts. Sophie spoke of her work in a CMHT and how at one moment a practitioner could be dealing with a high level risk situation, but a short while later when a home visit is carried out, it is discovered that the client has gone to the shops. This ambiguous client behaviour can cause practitioners to encounter worry in one instant, followed by frustration or relief later when the client returns home with their shopping, now feeling in a better frame of mind. This fluctuation in client presentation makes it hard for practitioners to ascertain the true level of risk, and therefore the required response to deliver. Practitioners indicated that the mixed messages they had received with regard to true suicidal intent, left them feeling deeply shocked on receiving the news of their client's suicide.

Gill reported having genuine reservations about working with her client due to the severity of his risk. Gill reflected that "…she was not working in the dark", and "…all the signs were there", yet she agreed to work with him against her better judgement. Gill questioned herself, saying "…what stopped me saying no"?, and thought about the favour she had done for the colleague who had referred the client. She then went on to think about how the client had presented, his expert knowledge of mental health, his desire not to have a mental health record, and his apparent slight improvement over the previous few sessions. Although the signs were there, Gill had felt unable to say no to the referral, nor to prevent her client's suicide. Gill was an experienced practitioner, but if she had discussed her concerns about working with this client with her supervisor, gaining another perspective may have allowed her to analyse her rationale.

When clients presented as suicidal, practitioners reported an increase in their activity in relation to offering additional sessions, texting in between sessions, writing copious notes, often resulting in them missing breaks and staying late at work. 64% of practitioners made adjustments to their schedule or work practices following client suicidal attempts, in contrast to 44% of practitioners making adjustments following their client's suicide. This variance could be due to the fact that nothing further could be done for the client who had died, leaving only adjustments to reduce future risk in unrelated cases.

Working with suicidal clients can be precarious for the practitioner, leading them to doubt their own decision making. In an effort to remain in control of the situation, practitioners may find that they are drawn into a number of activities in order to try and keep their client safe.

8.2.2 Transference and Countertransference

A further dilemma is that of transference and countertransference reactions; although not all practitioners recognise these concepts, most would acknowledge the unique thoughts and feelings which can be triggered through communication with their clients. Diane had asked herself many questions, but one in particular kept coming back, and that was why she had not attended to her client's depression more proactively. Diane was baffled as to why the client's depression was so obvious in hindsight, yet she described herself as being

"anaesthetised" and "sleepwalking". As a psychodynamic counsellor Diane was proficient in understanding transference and countertransference responses, yet with this client it was as if she was unconscious of a possible enmeshment with the client's own process.

There appears to be something incredibly powerful about the communication between suicidal clients and their practitioners; the data demonstrated on a number of occasions that normal interaction and behavioural processes were overridden. In the interviews, practitioners spoke of acting differently during the therapeutic relationship with their suicidal client, and on reflection they were surprised about some aspects of their own behaviour.

Mishane (2004) suggests that self-injurious behaviours can provoke profound anxiety and fear in practitioners, and recommends that more understanding is required to grasp the countertransference responses evoked in practitioners.

The data highlights that the intense suicidal turmoil experienced by suicidal clients is communicated via transference and countertransference responses. I believe it is of significant importance that practitioners have an understanding of this powerful process, in order to monitor their responses and to discuss in supervision the impact of such communication. If this process is not analysed with a supervisor or mature colleague, the practitioner could be left feeling emotionally bruised or wanting to withdraw from the client. I believe that if this continues over a period of time the practitioner may experience decreased motivation to work with clients, or eventual burnout.

The importance of understanding transference and countertransference responses is incorporated in my training workshop as a topic in its own right, but is also included in the area of using effective supervision and self-care methods.

8.2.3 Risk Assessment

When Stella thought about the suicide of Claire she recalled that "…she convinced us all" and we were "…under an illusion"; again, Stella had not seen the signs of Claire's suicidal ideation. Likewise, when Stella spoke of Claire's sister's decline into suicidal ideation (Jane), she reported having completely forgotten about Jane's past suicide attempts and any

impact of Claire's suicide on Jane. There would seem to be a powerful dynamic, where the practitioner on occasions does not acknowledge the strength of the client's suicidal inclination. At the time of her work with Jane, Stella did not have a supervisor; if Stella had been in supervision she may have had greater insight into historical risk factors which went forgotten and unnoticed.

Some practitioners would see the place of assessing risk at every session, depending on the context in which they worked, and the required level of scrutiny. However, for many of the practitioners who took part in this study, it would not have been their practice to work in this way. Despite varying opinions and viewpoints on risk assessment it is something which does feature in my newly developed training workshops. This is in response to participants' requests via the survey, as well as organisations asking me to deliver workshops covering this topic.

Research carried out by Martikainen and Valkonen (1996), Rostila et al (2012), Pitman et al (2014) and Barker et al (2014), stresses that people who have a family member kill themselves are at a higher risk of suicide themselves. Out of the eleven interviews with practitioners who had had a client kill themselves, one client had experienced a significant death, and five had experienced the suicide of someone close to them in the previous eighteen months. These deaths may have elevated the client's risk, and whilst I do not know if this was explored in their work together, having such information may have alerted the practitioners to the potential suicide of their client.

As outlined in previous chapters- and also highlighted above- communication with suicidal clients can be challenging, and ascertaining a true level of suicidal risk in the client can be problematic. Communication and risk assessment are crucial aspects of the work done within the helping professions. It is essential that practitioners gain the necessary skills via professional training, to aid them in the complexities of working with, and supporting suicidal clients appropriately.

8.3 The Emotional Impact of Client Suicide

Phase two highlighted that practitioners were affected considerably both by suicidal behaviour and by the actual suicide of their clients. The narrative analysis highlighted

themes such as feeling overwhelmed, inner torment, the struggle, the cost, and personal toll, being marked by the loss, becoming stuck and feeling horrified; these all demonstrated the gravity of practitioners' experiences. The thematic analysis raised the issue of information following an event being partial, with only elements of detail being available to the practitioner. Both the news of a client's suicide, as well as gaps in information seemed to cause a significant impact on practitioners. As in phase one, the complexity and challenge which practitioners faced when working with suicidal clients was felt acutely. It would seem that the profound nature of client suicide can make it hard to mentally compartmentalise, in the way that other client presentations can be put out of one's mind.

Grad (1996:139) suggests that in many cases death due to physical ill health can be deemed as inevitable, natural and even a welcome relief after a period of pain and suffering. "Suicide by contrast, is considered an unnatural event and one which should be avoided and preventable". Grad goes on to assert that "in every case" following a suicide, practitioners will berate themselves about what they "should" have done to thwart the death. Parker (2014:488) describes how following client suicide, practitioners ruminate on how to "undo" the suicide, resulting for some in a potential decline of their own wellbeing and functioning.

My data suggested that bearing the clients suicidal pain whilst holding a sense of responsibility, can leave practitioners feeling vulnerable both as a professional and also as a human being. The potential suicide or actual suicide of a client can activate the practitioner's own sense of fragility. Death in general- but suicide more particularly- can leave the practitioner profoundly aware of their inability to prevent death. Even if it is not considered to be within the practitioner's remit to keep clients alive, their client's suicide can evoke rumination leading to self-doubt about professional competence. Gitlin (2007), Jobes et al (2008) and Joiner (2008) state that it is the unique nature of the therapeutic relationship, and the fact that the practitioner is using their interpersonal aspects of self as the intervention, that makes the suicide of the client so problematic.

There is also the question of responsibility: is the client responsible for their actions, or is the practitioner responsible due to their training, experience and knowledge? For many clients the practitioner is seen as the expert: does that then indicate that the practitioner is neglectful or lacking in insight if the client kills themselves? Ellis (2004, 2012) provides a

helpful way of framing this dilemma in terms of three models- the therapist responsibility model, client responsibility model and the collaborative model. Ellis suggests that the first two models place unhelpful stress or blame on either the client or the practitioner. Whereas the collaborative model provides a shared responsibility in acknowledging the limitations held by the practitioner.

The data highlighted how often the practitioner is left with a myriad of thoughts and feelings which require processing. This can be very painful and the practitioner may try to protect themselves by not engaging with this process. In chapter five (section 5.4) there are examples of thoughts being both positive and negative and directed towards the practitioner, the client and others.

> *"I felt it was my fault" (thought in relation to self)*
>
> *"I was a bit angry as well as shocked - this seemed very manipulative" (thought in relation to self and the client)*
>
> *"Concern for his wife and 4 children and for his CPN" (thought in relation to others)*

The diverse range of thoughts and emotions expressed in phase one were dependant on various factors. Chapter five (section 5.3) highlights responses to question 7, and shows that practitioners experienced a genuine sense of relief in relation to help arriving, in the form of paramedics, health professionals or other team members, which then prevented the suicide of their client. Thus the need for reassurance and support at this time featured highly for practitioners. Conversely, a lack of support caused practitioners to feel isolated and withdrawn: some participants expressed a lack of support from their professional body, causing them to question its purpose at a time when they really needed expert advice and support.

Participants also expressed degrees of frustration and anger towards other health professionals and organisations. It sometimes seemed to them that, the client was always 'somebody else's problem', causing the practitioner to experience a tension within the health care system. This discrepancy was identified particularly with regard to levels of suicidal risk, duty of care and referral pathways.

Due to the unique issues that arose for practitioners, it would seem that many felt unequipped and out of their depth. This in turn caused significant emotional challenges, such as fear of their client trying to end their life again, fear of not having the resources to manage the clients' distress, and fear of personal and professional repercussions.

For practitioners whose clients had died by suicide, similar emotions were experienced to those of the practitioners whose clients had made suicide attempts; however, self-blame, disappointment and shock were also present for these practitioners. Answers to question 17 in chapter five (section 5.4), demonstrated that despite the passing of time, practitioners still commented that "You don't forget", "It has had a lasting impact", "and ''I have a very incomplete picture which will never change". It was clear that the consequences of client suicide mark the life and work of practitioners long after the event has passed.

8.4 The Rejection of Life

It would seem that following a client suicide, practitioners are confronted with the realisation that despite their best efforts, their client chose to kill themselves. This rejection of life and the therapeutic relationship left a number of practitioners reeling. Although death is occurring constantly around us in a general sense, it's occurrence in therapeutic treatment is relatively rare. So when a practitioner is confronted with a client suicide it can be unexpected and devastating, leaving the practitioner feeling blame, guilt or failure in relation to the death. It's impact is not restricted to the professional side of self, but can also rock the foundations of their thinking, and cause the practitioner to wonder about their own mortality and that of those they love; the certainty of death can converge and break into their comfortable existence. This is evident across both phase one and two of the data.

When Sonia's client killed herself, old memories of a family member who took his own life came flooding back. Sonia had feelings of guilt in response to her relative's suicide, and this impacted on her cognitive processing of her clients suicide. Although Sonia had worked closely with her client's GP, they were both unable to prevent the client's death. It was not Sonia's fault, yet she felt as if she had "committed" a crime, and had mental images of being exposed by her professional body. The efforts that Sonia's client made to ensure that she succeeded in killing herself seemed out of character for the small, prim, elderly lady whom

Sonia had worked with. Yet it was this determination which drove the client to an end which Sonia could not have prevented.

When Gill's client killed himself, she likened the devastation she felt to that of a "bomb going off in an enclosed room". The intensity of the initial reaction is often followed by soul-searching and self-questioning. Practitioners seem to ruminate about whether anything could have been done differently, or whether there were signs that had been missed. Whilst it is important to reflect on and analyse the circumstances around the client's suicide, the acuteness of the experience can lead to incessant questioning and provoke a sense of self-condemnation. This in turn can cause a strong emotional and behavioural reaction for the practitioner, at which time the practitioner needs to reach out to a supervisor, therapist, friend or loved one.

8.5 Learning from Client Suicide

As difficult as client suicide is for practitioners to face and deal with, it can also provide an opportunity to learn from, and even enhance one's own practice, thus providing a greater degree of client care. Stella held the view that it was not her place to persuade a client not to take their own life: she was very matter of fact in the way that she spoke of Claire's suicide. However, months later when Jane was suicidal, Stella did not allow her client to remain at home alone with her risk. Stella did something she had never done before and went to Jane's home, spending time with her and intervening to gain appropriate psychiatric support, in order to prevent Jane acting on her suicidal ideation.

As Stella spoke of this out of character act of attending to Jane in this way, she had an epiphany. Stella recalled that Jane had been abandoned by her mother, but as Stella sat with Jane in her bedroom she demonstrated deep compassion and care for her client: this realisation caused a powerful emotional response in Stella. This example illustrates how Stella's practice and awareness changed when confronted with the potential suicide of Jane.

I have found through delivering my training workshops that the case studies, experiential exercises, role play and discussion have allowed some practitioners to find new perspectives on previously held ideas.

Other practitioners disclosed how they had been able to learn from their client suicide. Paul spoke of learning to stay with difficult and troubling thoughts and feelings, in order to understand the client and respond in their best interest. Paul spoke of how he changed his practice due to these opportunities for reflection. Diane thought she had become a better counsellor due to the suicide of her client. There was a sense of not having the answers, but knowing that she had done her best. Sonia acknowledged that she had become more courageous and brave due to the suicide of her client. Sonia had also been able to develop training and resources for her counselling volunteers out of her own experience of client suicide.

Norcross and Guy (2007), Wicks (2008) and Lankford (2012) write helpfully on the need for practitioners to thrive in life, and not just survive. Lankford proposes that whether the event was a mistake on the part of the practitioner, or out of their control, there is a need to review and find opportunities for learning from the situation. This in turn will lead to insight and enable development of resiliency.

There are many thoughts and feelings to be negotiated following the suicide of a client, and this process is important to ensure that the practitioner does not suffer ongoing trauma. Practitioners spoke of not being able to forget, or of being 'marked' by the suicide of their client. Valente and Saunders (2002) state that practitioners need to grieve following client suicide, and that this process is facilitated when there is recognition of one's own mortality and being able to consider the death without defence. Yet perhaps this sense of acknowledgement is not always detrimental. In fact remembering the client and honouring their memory may be a respectful and healing behaviour for the practitioner.

8.6 Practitioner Self-Care

The emotional pain of a client can be a heavy weight for a practitioner to carry week after week. Yet it is one of the aspects of the therapeutic role which has to be endured. Karen mentioned this when she said:

> *"I'm like most, well a lot of people that go into this work- I'm also very porous so there is a level at which it disturbs me… which is very difficult and I think we have to be disturbed by our patients".*

Bearing the despair of a suicidal client can provoke strong feelings within the practitioner, such as anger or hopelessness. I am in agreement with Paul's statement, when he spoke of the need to work through client difficulties rather than referring them on to someone else. I believe where possible that it is in the client's best interest to keep them engaged within a helping relationship. However, this is with the proviso that the practitioner is working within their level of competence, and within a network of personal and professional support.

Sometimes when working within a helping profession, there can be an illusion that we will be able to help and heal all clients. Yet this will not be possible, and whilst we may do our best, the saving of others may not be within our remit. Working with acute suicidal despair can highlight the practitioner's own vulnerabilities and ordinariness: this level of powerlessness can be challenging for the practitioner to stay with.

Following the death of a family member or friend it would be acceptable to take time off work, attend to the needs of one's self and others, and go to the funeral. However, with the suicide of a client these acceptable practices are not always possible, due to the professional nature of the relationship. The sense of loss or bereavement may be acute, and yet we can struggle to allow ourselves to show these normal human responses which we need to work through.

Self-awareness is often developed by consciously considering personal beliefs, values, motivations, strengths and weaknesses. This process of self-reflection and analysis can occur through experience, training, personal therapy and supervision. To have considered these areas can help the practitioner to understand their part in the death of the client, what aspects they might need to reject and what they may need to own.

Bryant (2006), Zerubavel et al (2012) write about the dilemma of the wounded healer, and how unexplored personal struggles can cause the practitioner to be particularly vulnerable. The necessity of understanding one's own wounds is possibly even more imperative for those working closely with clients who are suicidal. The practitioner who has not considered their own brokenness, beliefs and frailty could lead to further complications such as burnout, compassion fatigue or trauma responses.

Macchi et al (2014) and Haarhoff, Thwaites and Bennett-Levy (2015) comment on the need for practitioners to engage in reflective practice. They go on to suggest that reflective practice can increase self-care, reduce burnout, increase morale and improve service delivery to clients. Figley (2002), Harrison and Westwood (2009), Maschi (2015) and Munson (2015) propose that practitioners who are exposed to traumatic client work, require self-care strategies to aid their internal and external resources.

Practitioners reported that self-care within their personal life included time spent enjoying hobbies and exercise, such as walking, keeping fit, yoga and running. Self-soothing, extra baths, massage and relaxation were all deemed to be useful along with the need to have specific things to look forward to like weekends away.

Spiritual discipline such as praying, meditation and mindfulness were also seen as supportive. Fortney et al (2013), Boellinghaus et al (2013) Benedetto et al (2014), Dorian and Killebrew (2014), Tan and Castillo (2014) and Lefevre (2014) all suggest that resilience is built and health maintained by having a spiritual practice, including areas of personal growth such as mindfulness- building strategies, self-care, physical exercise and meditation practice.

Tjeltveit and Gottlieb (2010) suggest that depending on the practitioner's view of self-care it can either lead to increased vulnerability or resilience. Alvarex-Gray (2016) reinforces the need for practitioners to be intentional in their self-care. They note that psychotherapists often neglect the need for a personal exercise regime. Kim and Windsor (2015) and Bush (2015) state that intentional self-care is not just essential, but is a survival tool. This raises the question of how, if practitioners cannot care for themselves, they can care for others. Very often we can recommend self-care strategies to our clients but neglect to implement them for ourselves, potentially identifying us as hypocrites. Strategies such as exercise, support networks and spiritual discipline, when connected with throughout the day can guard against excessive stress. In addition a healthy diet, sensible alcohol consumption and good sleep patterns are all essential for practitioner wellbeing. Practitioners who do not initiate self-care strategies could end up with emotional or physical health issues, or suffer from burnout.

8.7 Practitioner Support

The findings in relation to the quality of support practitioners received while working with suicidal clients highlights that 66% felt supported by their managers, and 89% by their supervisors.

8.7.1 Support from Supervision

Practitioners reported taking many positive steps to aid themselves following the challenges of working with suicidal clients. Support from professionals included time spent with supervisors discussing the implications of their suicidal client, devising techniques, considering boundaries and process issues, along with transference and countertransference concerns. One participant mentioned changing supervisors due to feeling unsupported and let down when her client went into suicidal crisis. Line managers and colleagues were also approached for support in decision making, to offload, seek reassurance, debriefing and for reflection. Some participants returned to personal counselling in order to consider material triggered by their work, such as revisiting experiences of family suicide.

Within the counselling and psychotherapy profession it is mandatory for practitioners to have supervision on a regular basis. This practice is something which is understood from the outset of professional training. However, my data has highlighted that for some professions such as support workers, nurses and social workers, supervision is not always provided and practitioners do not necessarily understand the benefits of why and how to use this important support provision. I would like to suggest that all practitioners working with suicidal clients should have access to a supportive supervisor, in order to consider the impact upon themselves, and their own responses to their clients. In order for this to become established, organisations and professional bodies need to understand the importance of providing this level of support.

Nobel and Irwin (2009: 346) suggest that the place of supervision is to aid “competent and accountable practice”. They highlight that within some professions there is a degree of uncertainty about the purpose of supervision, and how it differs from management supervision. Nobel and Irwin (2009:354) go on to stress that when used appropriately,

supervision can enhance clinical practice, along with knowledge and skills as well as providing an opportunity for personal reflection. “A critical lens” will help practitioners to make their actions and those of others “more explicit and conscious”, thus leading to greater insight and awareness.

Fairman et al (2014), Porter (2014), Pratt and Jachna (2015), Martens et al (2016), Foggin et al (2016) and Saini et al (2016) highlighted the lack of support and supervision for practitioners following a client suicide. After a significant event such as suicide, it is imperative that support is available to practitioners at both an informal and formal level as required.

8.7.2 Support from Friends and Family

Support from family and friends played a strong factor in gaining reassurance; care, supportive conversations, physical contact (such as hugs), and having time to socialise were all seen as important. When work pressures prevailed, there seemed a critical need to have a strong sense of stability at home, along with separating work and the rest of life. This idea of good work life balance is promoted by Figley (2002) and Kim and Windsor (2015), although there is a wide literature on the concept. Skovholt and Trotter-Mathison (2011) indicate that practitioners experience considerable stress in their work when they give more attention to their clients' wellbeing than their own.

Following a client suicide, it is crucial that the event and the practitioner’s part in it, is examined for their ongoing wellbeing. This needs to take place at the appropriate time and with the right friend, colleague, supervisor or manager. As highlighted in chapter six and seven, most of the practitioners spoke of the key role that personal and professional relationships played in the weeks and months following the suicide of their client. It is essential for the emotional equilibrium of the practitioner to be restored in order to care for themselves, and to continue to care for their other clients. Alexander (2007) wrote of needing a holding environment following client suicide:

> “*There were no magic words or rules to repair me. I needed colleagues and family willing to be with me in my distress; they were soothing by their presence and non-judgemental attitudes”. (*Alexander,2007: 76)

8.7.3 Support within the Workplace

The data demonstrated the need for practitioners to take self-care precautions within the workplace, such as not taking on additional commitments or allowing themselves extra time at work for tasks. Participants also expressed the need to care for themselves by not attending difficult meetings, making space in their day to reflect or just 'be', and taking regular breaks for food and time out. Participants highlighted the need for a clear boundary of mentally 'leaving the client at work' in order to care for themselves at home.

Ellis (2012) suggests that emotional balance can also be found by sharing the incident with another practitioner who has experienced client suicide, and also in the reading of first-hand accounts. The importance of normalising the understanding of emotions and self-critical thinking is vital to aid healthy recovery. Kimball (2016) reports the need for practitioners to recognise that they are not alone in their experiences following a client suicide. This is part of my motivation to produce a book outlining the first-hand accounts of practitioners' experiences and survival strategies following their client's suicide.

Whatever setting the practitioner is working in, it is essential to establish a network and to form links with other professionals and teams. The benefit of having clear communication and possible referral pathways is particularly relevant if a client goes into crisis. Forging relationships may be easier for those working in a health care setting. Sophie spoke of the relief she experienced at being able to leave work at the end of the day, knowing that her clients were going to be cared for by other members of the team. However, for those in private practice the need to work in partnership with GPs and crisis teams could contribute to greater client and practitioner support.

Practitioners with strong collegial relationships with GPs in particular, reported a shared sense of client care, as it was in the case of Sonia. Those who did not have good relationships with GPs were faced with defensiveness, which fuelled further self-questioning and blame, as in the example of Diane. I would recommend that training providers highlight the necessity for practitioners to research and build links with key people and services within their communities.

These links with colleagues are not only important in order to support the client, but in the event of a client suicide they are also imperative for the practitioner. Many of the practitioners in phase two spoke of the value of having an understanding colleague, supervisor, manager or team who contributed to their regaining of clinical confidence.

Some practitioners observed that their work environments were stressful most of the time, with some services having staff signed off sick due to depression, anxiety, stress and burnout. The cause of these stressful work environments is often down to the volume of work, poor processes and systems, unrealistic expectations from management and a lack of support.

Senior managers can sometimes be out of touch with the issues faced by staff and clients, with clients being viewed as just a number. This distancing by management can prevent staff from acknowledging their own feelings of vulnerability following a client suicide. It can also create unsupportive environments, which in turn can lead to practitioners becoming stressed, anxious and unable to work effectively with their clients.

Andrea identified that her work place did not provide her with the right level of supervisory support, and so she paid for her own supervision to ensure that her needs were met. However, a small number of practitioners did not seem aware at the time of their client suicide of their own needs resulting in stress, anxiety, low mood and poor sleep. If someone does not have the self-awareness to recognise what they need whilst working in a stressful environment, it is concerning as to how they can best be supported. I would like to suggest that training providers and employers take a greater degree of responsibility for preparing and supporting staff. This can be achieved through informing practitioners of the need for self-awareness and self-care via a reflective space, how to use clinical supervision and robust line management, to identify the power of transference and countertransference responses, to reflect and recognise their own needs and develop self-care strategies when working in stressful environments, and the processing of incidents in a non-blaming manner.

Whilst many practitioners coped following the death of their client due to the support they gained from their colleagues and organisations, others questioned the support they had received, along with the organisational ethics and values of their employers: the

implications of this can be detrimental to both clients and practitioners. Although investigations need to take place following a client suicide, they must be carried out with sensitivity and respect. Clearly issues must be highlighted and lessons learned, but the way in which this is undertaken needs to be done in the best interest of both clients and staff. For some organisations, it appears that anxiety about their reputation may cause them to dismiss or hide poor practices.

Storm-Gottfried and Mowbray (2006) provide suggestions for organisations to consider in order to support their staff following a client death. These include supervisors being able to identify staff who may be experiencing compassion fatigue and other problematic symptoms, decreasing caseloads, along with promoting self-care in the workplace. They go on to emphasise that supportive, caring work environments need to be created, and that staff who experience high levels of workplace support will have lower levels of burnout and stress. Butler (2016) warns of the need for professions to take more responsibility than just acknowledging the challenges faced, but to go a step further and be intentional about addressing them. Gilroy (2002) highlights that workplace stress needs to be addressed at a systematic level, and that employers have a moral imperative to achieve this.

Erbacher et al (2015) proposes the need for organisations to have clear supportive processes in place to aid staff and prevent burnout. Hawkins and Shohet (2000), Reeves and Nelson (2006), Reeves (2010, 2015), Takahashi et al (2011) and Martens et al (2016) highlight the need for supervision and workplace support. Maertz et al (2007) carried out research into the relationship of organisational support and perceived supervisor support. One of their findings suggested that good workplace supervision…

> "…*may be able to cover for the shortcomings of organisational policies and top management decisions that seem unsupportive".* (Maertz et al,2007:1072)

Kim and Lee (2011:381) carried out research into organisational support for social workers, and they concluded that service managers need to provide support not only for frontline staff, but also for the supervisor, due to the "critical assets and resources" which they provide for organisations.

Sodeke-Gregson et al (2013) found that maturity, time spent engaging in research and development activities, a higher perceived supportiveness of management, and regular supervision predicted a higher potential for self-care. In contrast, youth or inexperience, and lower perceived supportiveness of management predicted a higher risk of burnout. However they also found that those at greater risk of burnout included practitioners who were having more individual supervision and activities, as well as those who had a personal trauma history.

Employers need to take staff welfare seriously in order to prevent burnout and poor mental health. Following a client suicide it is even more urgent that staff are well cared for by their employers.

8.8 Practitioner Training

In phase one, practitioners commented on the preparation they had received from their training to work with suicidal clients in the following way:

27% (*n*=30) of practitioners rated their training as poor or unsatisfactory

24% (*n*=26) suggested their training was average or satisfactory

49% (*n*=54) deemed training as good to excellent

A number of participants expressed that whilst they did receive training on how to work with suicidal clients, the theory did not adequately prepare them for the emotional experience of the work.

Practitioners indicated multiple areas which they would like to see covered in preparation for work with suicidal clients, including myths about suicide, identifying suicidal intent, interface with other professionals, self-support and how to cope following a client suicide. Suggestions were made to include experiential learning, and although role play made some people feel uncomfortable or nervous, participants recognised its' value for this type of work. Debski et al (2007) highlight the need for systematic training to enable practitioners to work confidently with suicidal clients. They suggest that role play is an important part of

the training process to give students the opportunity to practice in a safe environment: this viewpoint is also supported by Shea (2009).

Participants proposed that core professional training needed to include modules on working with suicidal clients, followed by refresher training on a regular basis. It was also acknowledged that professional bodies and organisations needed to lead on disseminating research findings and best practice to aid practitioners.

Following the suicide or attempted suicide of their client, some practitioners reported being left feeling risk- averse, whilst others wrote of experiencing personal and professional development, learning, self-awareness and resilience. Rollins (2011) highlight that practitioners who experience adverse events such as the suicide of a client, bereavement, abuse, divorce or a trauma, if it is dealt with appropriately, can foster personal resiliency and an increased sense of client empathy, and clinical effectiveness. I believe that a crucial area of professional training and clinical supervision for practitioners is to learn how they can use reflective practice to understand themselves and their responses to their clients.

Appendix O shows a cross reference of data from phases one and two for the eleven practitioners who were interviewed and their comments with regard to the training they received. From this comparison of phase one and two data there appears to be a number of contradictions in practitioners' ratings and comments.

The practitioners' ratings for being prepared by their training to work with suicidal clients ranged from six practitioners specifying their training was poor to average, and five stating that it was good to excellent.

Julie rated her training on the survey as being good to excellent but in her interview said "It didn't prepare me at all", whereas Karen rated her training preparation as average to satisfactory, but then went on to say in her interview "I have had a lot of training but not specifically working with suicidal clients".

Andrea suggested that her training was poor, and Gemma stated that she did not receive any preparation. This disparity in preparation is of concern, considering that each of these

practitioners had been working with suicidal clients for a considerable time, and in a variety of settings.

Diane thought that she had received excellent training, yet wondered whether practitioners sometimes think suicide happens to other people's clients and not their own. Diane suggested that this may lead to practitioners not enquiring sufficiently to gauge the full extent of suicidal ideation.

Sophie who had a leadership role with a CMHT stated:

> *"I've had no training of dealing with a client's seriously self-harming or committing suicide. I've not had any training in how to cope with that or how to help other people cope with that so I think there is a bit of a gap there."*

Similarly Paul reflected:

> "*When I first started psychiatry, I didn't actually get any training on suicide assessment but by that time I was an experienced clinician so I worked it out".*

Karen a psychotherapist and supervisor reported:

> *"I haven't had specifics but there probably is …and I could probably do with it myself really as I appreciate that there might be new information and sites about suicide and it would be good to…there is nothing like knowledge, and we are learning things from the inquiries and the like. I think yeah definitely let's hear about it and don't be frightened of asking questions".*

Sonia was unsure if anything specific from her professional training would have necessarily helped her. However, in her role of managing volunteer counsellors Sonia had devised a comprehensive training programme, to ensure that her volunteers were well prepared for the challenges of working with suicidal clients.

Andrea struggled to recall any training on suicide from her counselling diploma or agency induction, but reflected that it was her life experience which had helped her the most. Gemma in her role as a support worker had not had any training to work with suicidal clients, but wondered whether having some preparation at the start of her employment

would have been useful. Julie trained as a nurse twenty years ago and did not have any preparation for working with suicidal clients; however, she put the key to surviving this work down to reflective practice and supervision.

The data indicates gaps in training provision across the professions, and is a significant concern. This poverty in training preparation for practitioners is validated in research carried out by De Angelis (2011) , Takahashi et al (2011), Lerner et al (2012), Prabhakar et al (2013), Figueroa (2013), Heyman et al (2015) and Foggin et al (2016).

Whilst practitioners' assessment of their professional training is a source of concern, the suggestions made for adaptations to training are extremely valuable. At the outset of this thesis I wanted to learn from practitioners' own experiences to produce training which is relevant to their needs. I believe that the data and stories expressed by practitioners have allowed me to accomplish this objective. The data from phase one and two of this research has steered the development of my training products which will be outlined in the next chapter. The participant evaluations I have received from the training events over the past year have demonstrated that practitioners are benefiting from the opportunity to examine and learn more about the subject of working with suicidal clients.

8.9 Shared Professional Responsibility

In section 8.3 of this chapter I referred to Ellis (2004) and (2012) who provided the concept of a collaborative model of shared responsibility for working with suicidal clients. I would like to propose taking this idea of shared responsibility a step further by suggesting a wider framework of responsibility than just client and practitioner. Figure 12 highlights the concept of shared professional responsibility:

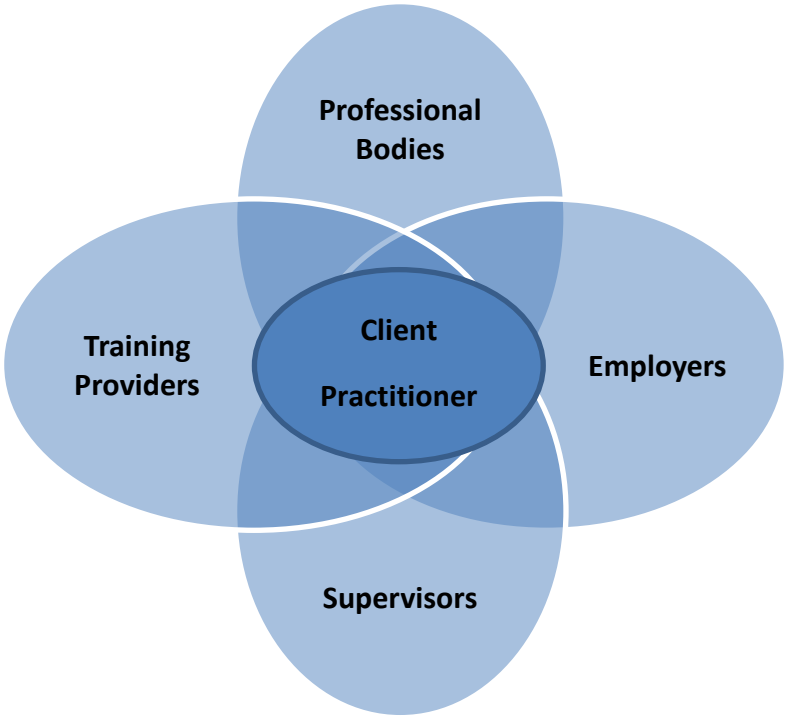

Figure 12: Professional Responsibility Model for Working with Suicidal Clients (Scupham 2016)

Shared professional responsibility highlights the interactive way in which related areas of support for practitioners can be formulated. Whilst these areas already exist, I believe that it is vital that support for practitioners who have experienced client suicide is seen as a *shared* professional responsibility.

It is essential that training not only prepares practitioners for working with suicidal clients, but also contributes towards continued professional development. Best practice, learning from investigations into incidents of suicide and research updates must be incorporated into ongoing training delivery. Supervisors need to support but also to sensitively explore with practitioners what can be learned from the experience. Professional bodies must lead on providing advice, guidance, signposting and support for practitioners whose clients have killed themselves. It should also be a prerequisite that professional bodies disseminate research findings and professional updates to ensure that the profession is at the forefront of best practice. Employers have a responsibility to their clients and staff: clients are more than just a number, and respect from management needs to be demonstrated in policies and procedures in relation to all aspects of client care, but particularly for risk assessment

and risk management. Following the suicide of a client it is essential that employers ensure staff members are given appropriate support in relation to their individual needs. The suicide of a client will continue to be a difficult experience for practitioners, but if training providers, supervisors, employers and professional bodies can work in collaboration the process of recovery and support for the practitioner will be optimised.

8.10 Relevance of the Research

Throughout this research I have endeavoured to follow Elliott et al (1999), Stiles (1993), Yardley (2000) and Morrow's (2005) guidelines for validity, quality and ethics. In chapter four (section 4.8) I evidenced these critical areas under the headings of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance as proposed by Yardley (2000). The commitment to these principles has provided a firm foundation for the efficacy and relevance of my research.

Patton (1990:255) recommends that validity comes from having "information richness of cases" and this is certainly something which has been generated from both phase one and two of this research. When I commenced this research study I wanted to hear practitioners' stories, and ascertain ways of supporting professionals which originated from their lived experiences and needs. The training I have devised has evolved directly from the data and information rich stories as told by the practitioners.

Participants who were interviewed were given the chance to speak about their very personal and private experiences of client work. Some participants they had previously only spoken in a very limited way about the events surrounding the suicide of their clients. Having the opportunity to be interviewed allowed some practitioners to express things which had not been previously voiced. Sonia, Diane and Paul amongst others, spoke of an awareness of having developed in their confidence, ability and resilience, whilst other participants conveyed epiphanies and stories of enlightenment and personal growth. Some participants expressed an appreciation to me for having listened to their stories, and providing an occasion for them to contribute to a valid area of research. Riessman (2008: 63) suggests that 'Stories can indeed accomplish change'.

These interviews gave an insight into the gravity and impact of client suicide which in turn has provided valuable case examples for the training workshops. These case examples have also proved to be powerful illustrations within conference presentations.

In developing the training, I was not surprised that practitioners requested further understanding in relation to exploring issues of risk and suicidal intent. However, I had not expected that self-care would feature so highly as a required topic for training. I had been blind to the lack of care we show ourselves, and the unhealthy expectations of employers in some sectors. Stiles (1993) comments on the importance of researchers being explicit about what has surprised them, what they have found difficult, and how the research has affected them: my personal reflections on these aspects have been interwoven throughout this thesis.

8.11 The Limitations of the Research

A strength, and yet also a limitation of this study has been the volume of data. Choosing to use a mixed methods approach has provided rich data, yet I have found the sheer volume to be overwhelming at times. I have endeavoured to work in an orderly manner yet as structured as I have tried to be, I have on occasions repeated analysis which had already been completed. I can relate to Boyatzis' (1998) words when he warns researchers of a possible pitfall with thematic analysis, of becoming lost whilst exploring the data.

Although I interviewed and transcribed sixteen accounts, I decided to use only the interviews of the eleven practitioners whose clients had taken their own lives. This decision was taken due to the large amount of data I already had gained. However, the remaining five interviews given by practitioners whose clients had made attempts to kill themselves during the course of treatment will not be discarded, but instead formulated into an article with the view to having it published.

Another limitation is the high ratio of counsellors/psychotherapists in relation to other professional groups, which has meant having a smaller number of participants from groups such as psychiatrists, nurses and support workers. Chapter 5 (section 5.1) highlights the percentages of participants by profession. The disparity in numbers does mean that there is

a limited perspective from certain professions, but their individual stories are significant and as case examples there is a lot to learn from their experiences.

My initial intention was to keep the narrative accounts from the interviews as intact as possible so they would retain their authenticity. However, due to the amount of data, using a mixed methods approach and having limited word count for the thesis, I chose to use a simplified method of narrative analysis. I do not believe that this simpler process of analysis has diluted the richness of the stories, and the fuller narratives will be used for a book of practitioners' accounts, with the view to it being published following the submission of this research project.

A further limitation of this research is that I carried out the study with my own weaknesses, learning difficulties, psychological fatigue, and my own biases, viewpoints and beliefs. This could mean I have identified themes that someone else analysing the data may have interpreted differently. There could also be flaws and inaccuracies in the interpretations due to my positioning and perspective. Morrow (2005) refers to the need for the researcher to remain naïve in their interpretations, and Rossman and Rallis (2003:69) promote the researcher as being part of a "community of practice", in which respected colleagues can be consulted and provide critical input and discussion. As a fallible human being I have endeavoured to remain naïve and curious, along with relying on valued colleagues to share their perspectives and ideas.

8.12 Summary

In this chapter I have sought to discuss the salient points from my research in relation to practitioners working with suicidal clients, and the effect that it has on them if their client dies. Working with suicidal clients can be challenging due to the practitioner's lack of certainty as to the client's true suicidal intent. This in turn can make decision making hard to achieve, along with confusion due to transference and countertransference complexity.

When suicide does occur, the practitioner can feel shocked- as in the case of Diane who indicated that perhaps people assume suicide happens to other people's clients. It would seem that client suicide causes practitioners to feel out of their depth, and unequipped to deal with the aftermath. However, whilst client suicide affects practitioners profoundly, it is

something which can be overcome, and in phases one and two of this research it was evident that practitioners recognised a sense of resilience within themselves. This resilience was demonstrated as practitioners outlined their personal growth, professional learning and self-care strategies. Diane identified that she had become a better counsellor, Paul acknowledged the need to learn from difficult client work, and self-care was undertaken at work and in general life.

Support was a crucial element in the recovery period following client suicide, and it was recognised that this could be provided by friends, family, colleagues, supervisors and managers. Organisations which provide supportive environments are less likely to have staff experience work place stress and burnout following client suicide.

It was identified that the provision of training to work with suicidal clients was necessary, as part of both practitioners core professional training and their ongoing continued professional development. Both initial training and ongoing continued professional training will enhance general competence, increase knowledge, enable problem solving skills and improve confidence.

The importance of having a shared professional responsibility was also highlighted as being crucial in the ongoing support of practitioners following client suicide. Professional bodies, employers, training providers, supervisors and practitioners need to work together to maintain standards of care, support and training. This will aid and prepare practitioners for working with suicidal clients, and should their client die by suicide practitioners will have a greater degree of support to enable them to negotiate the challenges in the days, months and years which follow.

A pluralistic perspective would suggest there is not a single answer to the issues raised in this research. Practitioners are all different, working in a variety of settings and contexts with different needs and levels of support. My motivation for using a relatively complex mixed methods approach was borne out of my curiosity and a desire to consider varying perspectives and different practitioners' viewpoints. A broad data set has also enabled the development of different products for quite different audiences. Crucial to the idea of pluralist research is that each element of the data set could be used in conjunction with one

another, so as to moderate and enhance the understanding of each element by using the perspectives offered by each of the other elements. Looking at the data from more than one position has allowed me to see that following client suicide, practitioners will be able to negotiate the difficult days ahead if they have a number of support mechanisms available to them. This would include the capacity to reflect on their client's death with a colleague or supervisor, to have a good self-care plan established, to work in an environment which is supportive, and to have had training which has prepared them to recognise and handle the challenges they may encounter following the death of their client.

In the next chapter I will outline the products I have devised as a consequence of completing this study.

Chapter Nine: Research Products and Impact

In this chapter I will discuss the development and delivery of the products I have devised, which result from my doctoral project.

In chapter one I highlighted that research literature has identified the challenges practitioners face when working with suicidal clients, with some papers acknowledging current deficiencies in professional training and support. However, proposed solutions were not always provided and researchers indicated that further research into these areas was necessary in order to bridge the gap.

In the first chapter I also outlined my research objectives as the following:

1. To design materials to provide continuous professional development (CPD) via workshops and seminars;
2. To disseminate learning and knowledge at Health Care, Counselling and Suicide Prevention specific conferences;
3. To provide specialist insight into NHS and IAPT forums;
4. To influence NHS policy on support and training for practitioners working with suicidal clients;
5. To contribute to the current body of research in this field;
6. To publish a book containing the accounts of practitioners' experiences.

Unlike my earlier MSc project, which explored the experiences of counsellors and psychotherapists working with suicidal clients, the doctoral project sought to gain the views of practitioners from a wider variety of professions and to identify the training and support needs. I anticipated that by achieving the objectives above, I would make a tangible contribution to professional expertise in this area, which would provide relevant skills, confidence, insight, resiliency and support to practitioners when working with suicidal clients.

9.1 Research Products

The first objective, and the main product of this research project, has been the development of a training programme which I have delivered via workshops and seminars since November 2015. Although there are a number of organisations and individuals providing workshops and training courses on working with suicide, I had identified a number of gaps. Existing training focused on areas such as risk assessment and risk management, providing practitioners with largely theoretical knowledge. The training material that I have devised has not just been theoretical but also experiential, and has been produced directly from my research data. The focus of the newly developed training is on enabling practitioners to assess their beliefs about suicide, and to consider its' impact on their own wellbeing. In pre-existing training resources, inclusion of both of these aspects has been minimal (if mentioned at all).

9.2 The Workshops

Following the completion of analysis of each stage, I gathered all the information from the surveys in relation to practitioners' views about training. This included statistics, the training participants had received, suggestions for relevant training, as well as participants' general comments from the survey at phase one (as highlighted in chapter five). I also referred to the explicit and implicit content raised via the interviews at phase two of the research (as evidenced in chapter six and seven).

From this data base, I formulated potential training topics, and started to develop training modules suitable for practitioners at varying stages of professional experience, with the aim of preparing and supporting them for the challenges of working with suicidal clients. During this process I remained mindful of the various professions represented by practitioners who took part in my research. This was considered important because the needs of a psychotherapist in private practice for example, may be very different to a support worker working on a psychiatric inpatient ward.

The training modules I developed for the new workshops are shown in the following list:

- Assessment of risk
- Attending the Coroners court
- Best practice in supervision
- Contracting
- Creating a healthy workplace
- Deadly depression
- Escalation factors
- Group dynamics and the suicidal client
- Handling telephone calls with clients at risk
- Having assertive conversations in order to refer on
- Historical views of suicide
- How to cope following client suicide
- Identifying suicidal intent
- Legal and ethical issues
- Management of risk
- Managing the session with the suicidal client
- Managing boundaries
- Myths about suicide
- Network of support and referral pathways
- Personal view points and beliefs
- Protective factors
- Reflective practice
- Self-awareness
- Self-care
- Statistics on suicide
- Supporting staff after client suicide
- Transference and countertransference issues
- The investigation process

- The relationship between self-harm and suicide
- Working with feelings of hopelessness

9.2.1 Promoting the Workshops

Towards the end of 2015 and the start of 2016, I emailed organisations and key individuals who had responded to the research questionnaires. I offered bespoke training tailored to meet their requirements, lasting from 2 hours to a full day depending on the time that they had available (see Appendix P of my promotional flyer).

Organisations then informed me of their team requirements and I planned the training accordingly.

9.2.2 Workshops Delivered

Below is a list of workshops which I have delivered (with in excess of 300 people attending):

- 17 November 2015 (Berkshire NHS Healthcare Foundation Trust) 50 people in attendance
- 12 December 2015 (Aylesbury College, Buckinghamshire) 35 people in attendance
- 17 January 2016 (Aylesbury College, Buckinghamshire) 32 people in attendance
- 27 January 2016 (Mothertongue, Reading Berkshire) 4 people in attendance
- 20 February 2016 (Time to Talk, Great Missenden Buckinghamshire) 28 people in attendance
- 23 February 2016 (Berkshire NHS Healthcare Foundation Trust) 25 people in attendance
- 1 March 2016 (Berkshire NHS Healthcare Foundation Trust) 25 people in attendance
- 19 March 2016 (Aylesbury College, Buckinghamshire) 34 people in attendance
- 11 June 2016 (Time to Talk, Saunderton, Buckinghamshire) 13 people in attendance
- 15 June 2016 (Berkshire NHS Healthcare Foundation Trust, ARC Counselling, Mothertongue and Berkshire Counselling Centre) 48 people in attendance
- 7 October 2016 (Berkshire NHS Healthcare Foundation Trust) 25 people in attendance
- 10 December 2016 (Aylesbury College, Buckinghamshire) 35 people in attendance

9.2.3 Workshop Content

Prior to the delivery of each workshop I discuss the expectations and requirements for the training with the manager or organiser, also clarifying the professions of those attending, their levels of experience and any relevant previous training.

Appendix Q shows the training plan for a full day workshop which I delivered on 20 February 2016 to an organisation called Time to Talk (Youth Counselling Service). Time to Talk had requested the following topics:

1. Signs of when a young person may be at risk
2. How to assess the risk
3. Self-care
4. Strategies, strategies, strategies

The training plan for the workshop with Time to Talk shows how the first part of the session was spent on introductions and building a rapport between myself and the group. I shared the planned learning outcomes at the commencement of the session, to enable the group to know what to expect. I then established what the group required in order to gain the most learning and insight from the day, and elicited from them any specific individual needs. This was followed by drawing up a collaborative agenda of how we anticipated meeting the needs of the group, and at key points during the training I revisited the agenda to check that we were 'on track'.

One element of such training- which needs to be highlighted early on- is that the training may arouse strong feelings, and that group members need to be mindful of self-care throughout the day. Another crucial element when delivering this type of training, is to ensure that those in attendance are aware of their own agency or organisational policy and procedures for managing suicide and related risk. As each organisation has distinct policies, it is important that participants have a clear understanding of what their organisation expects of them.

In the training I delivered to Time to Talk (see Appendix Q), the initial exercises required participants to consider their organisational policies/procedures and how they work with

depressed clients. Participants worked in pairs and small groups, primarily to enable each group member to contribute to the discussion, and to formulate their own thinking on the subject. After completing each exercise, groups would feed back to the wider group so that learning and views could be shared.

To optimise learning, I organised a variety of activities including individual, small group and whole group tasks, supported by YouTube video clips. I was responsive to the mood and atmosphere in the training room, and adjusted exercises accordingly. The morning session provided a foundation of knowledge, which was followed in the afternoon session by interpretation in clinical practice, focusing on role plays, tutor demonstrations and case studies. These exercises became progressively more challenging, in order for participants to experience greater degrees of client suicidal complexity. The final part of the workshop was spent considering the importance of self-care, and the need to be proactive in planning self-care strategies.

In 2004 when I completed my counselling supervision training with Judy Ryde and Joan Wilmot(from the Centre for Supervision and Team Development ,CSTD), I was impressed by the way in which they embodied the relevant information, and implemented the training in response to the group's needs. I recall speaking with my supervisor at the time about how much I appreciated Joan and Judy's style. I have sought to develop a similar style and to be very spontaneous and relevant to the group's needs, which I believe has enabled my training sessions to be dynamic and engaging.

9.2.4 Evaluation and Impact of the Workshops

Evaluation is an important part of the learning process, and I always inform participants at the start of a session that I would like to hear their views on all aspects of the workshop. I then leave time towards the end of the day for evaluation forms to be completed. I take time to read and make a note of what has been appreciated, and what could be improved. Appendix Q provides an example of the type of evaluation form I use for workshops, and the evaluative feedback from my workshop with Time to Talk.

Below is a sample of the comments from the Time to Talk Workshop on 20 February 2016:

"I have enjoyed the day very much and this is due to the positive and very natural way it was delivered. You kept me interested throughout the day with a good mix of presentation and small group work".

"Susan made this topic accessible and relevant. Her delivery made what could have been a very heavy session informative and engaging".

"I am going away and feeling more capable in dealing with two clients that I am currently seeing. Thank you".

"Humour in a suicide workshop! Thank you so much for your warmth and realness".

"Role play was very relevant".

"Equation of suicidal intent is a tool that gives me more confidence going forward".

The feedback from the group was extremely positive with regard to content, training methods and delivery style. The majority of attendees rated the training good to excellent in all categories. Constructive feedback included comments from one participant who indicated that they would like to have spent a greater amount of time covering self-care, and several others would have liked to have had more input in relation to referral pathways.

One participant requested "less person centred bashing". Whilst it was not my intention to be derogatory, I did refer at times to various theoretical orientations in relation to possible viewpoints on risk assessment. I mentioned that some person centred therapists may not use risk assessment in the same way as perhaps a CBT therapist in the NHS.

Constructive feedback from other workshops has generally been in relation to requesting a greater amount of time spent on certain activities. I have found this particularly challenging when working with larger groups, and where possible I like to keep group size below 25 in order to give adequate time and attention to individuals.

9.2.5 Co Trainer

Over the past six months I have begun to deliver the NHS training workshops with another presenter. My colleague is a very experienced mental health nurse, and it has been mutually beneficial to work alongside her and present the training together. One positive aspect of

working with a co presenter has been that we are able to provide demonstrations and role plays. Working with a co presenter also provides greater monitoring of group dynamics, and the opportunity to reflect on the training process together.

9.2.6 Video Training Session

Below is a link to a training workshop I delivered on 10 December 2016 at Aylesbury College.

The clip provides an example of me facilitating learning in a first year counselling diploma group. The morning session covered mental health and depression, and the afternoon session focused on understanding suicidal risk in depressed clients. As the students were only three months into their training, this was the first time that the subject of suicide had been covered. However, in March 2017 (the group's second term) I have been invited back to deliver a follow up session on suicide and risk. Below is a sample of comments:

> *"Loved the teaching approach. Made a difficult subject enjoyable and not overwhelming".*
>
> *"I enjoyed this workshop and found the skills and supervision role play useful and interesting".*
>
> *"I liked the inclusion of self-care in the session. I think it's useful for us to focus on this every time".*
>
> *"Really valued Sue's style and approach – relaxed, fun enjoyable. Could see elements of the counsellor I want to be".*

www.training-video.scupham.net

9.2.7 Self-Care Workshop

As a result of my findings in relation to staff being off sick with stress, anxiety, depression and burnout (as evidenced in chapter five, six and seven), the importance of self-care for practitioners has become a priority for me. I have begun to deliver a self-care module as part of induction days for Talking Therapies (BHFT) (see Appendix R for PowerPoint slides).

Whilst only been two workshops have taken place, and there has not been significant feedback, I believe that it is important for the workforce to know that management acknowledge staff self-care as a priority.

9.3 Conference Presentations

My second doctoral objective was to disseminate learning from my research at relevant conferences and seminars, and over the past two years I have had the opportunity to present at three research conferences.

9.3.1 International Association for Suicide Prevention Conference

The first was for the International Association for Suicide Prevention (IASP) in Montreal in 2015. This conference is convened every other year, and has a five day programme on a wide spectrum of suicide related subjects. Out of the hundreds of symposium, poster and oral presentations very few directly related to the impact of suicide on practitioners.

The presentation was well received, and I was asked pertinent questions in relation to my mixed methods approach. Participants were particularly interested in the impact that suicide has on practitioners, and were in agreement that very little has been written in relation to this area. Appendix S provides my presentation proposal and the conference programme details. Having the opportunity to present my research at an internationally recognised conference enabled me to appreciate the value of this research, and confirmed how much I actually knew about my subject.

9.3.2 British Association for Behavioural and Cognitive Psychotherapy Conference

The second conference I presented at was the British Association for Behavioural and Cognitive Psychotherapy (BABCP) in 2015. I was the first of four presenters, and the symposium was entitled ‘Suicidality: Basic Processes, Interventions and Staff Experiences’. My presentation was well attended and people showed a keen interest in my research. I was commended for my presentation style, ability to communicate complex material in a clear and understandable manner, and several people asked to be kept informed of my research as it progressed. The conference programme details can be found in Appendix T.

9.3.3 British Association for Counselling and Psychotherapy Research Conference

The third conference was the British Association for Counselling and Psychotherapy **(**BACP) research conference in 2016, and my presentation was chaired by my Academic Consultant Dr Andrew Reeves who was also the BACP Chair in 2016. The session went particularly well with a lively question time. The questions highlighted how practitioners were fearful of client suicide occurring, and feeling unequipped to work with this client group. Appendix U provides conference programme details, PowerPoint slides and participant evaluation provided by BACP.

9.4 National Health Service Forums

My third research objective was to provide specialist insight at NHS and IAPT forums. As my research became more prominent, I was invited to present at two NHS conferences. The first was at the Accreditation Programme for Psychological Services (APPTS) 2nd Annual Forum, held at the Royal College of Psychiatrists in London on 14 November 2016 (see Appendix V for the forum programme details). The second occasion was for the Centre for Quality Improvement Learning Event on Suicide and Self-Harm, also held at the Royal College of Psychiatrists on 17 January 2017 (see Appendix V for the forum programme details).

Both events were attended by NHS Service Leads and staff from a wide spectrum of services including IAPT, CMHTs and Drug and Alcohol services. Following my presentation at the November conference the emphasis of the questions I received were around staff stress, toxic working environments and practitioner self-care. It would seem that workplace stress is a significant issue across a number of professions. When I commenced my research, this was not a subject in which I expected to make a contribution, yet stressful work environments seem a very relevant research topic at this present time.

9.5 NHS Steering Groups

My fourth research objective was to influence NHS policy on support and training for practitioners working with suicidal clients. During 2016 I was invited to join three NHS

steering groups, those being the Risk Training Steering group, the Staff Debriefing and Support group and Towards Zero Suicides group.

Although my participation in these groups has been minimal at the time of writing this report I anticipate that in 2017 I will make a contribution in the areas of staff training in the NHS, postvention support for those practitioners bereaved by suicide, and take an active role in shaping policy in working towards reducing client suicide.

9.6 Further Opportunities

In addition to delivering training and presenting my research at conferences and forums I have also had the following opportunities:

2015

- I was invited to write a review for a book entitled 'Suicide in Schools' which was published by Routledge in February 2016 (see Appendix W).

2016

- I was asked to contribute an article to a BHFT staff journal called 'Learning Curve', on using risk assessment tools in therapy
- I was invited to speak at the BHFT Annual General Meeting
- I presented my research at the BHFT Research Forum
- Following my attendance at the BACP Research Conference I was interviewed on counselling within IAPT services (see Appendix X).

These opportunities have all come about as a result of my research.

9.7 Post-doctoral products

My fifth and sixth doctoral objectives were to contribute to the current body of research on the subject of suicide, and to publish a book containing the accounts of practitioners' experiences of client suicide at first hand. The compilation of stories would each provide a glimpse of the challenges of working with client suicide. Although I had read a considerable amount of relevant material, I had not come across a book such as this, reflecting the

honest accounts of this challenging aspect of work faced by practitioners. I believed it would provide readers with a side of therapy rarely spoken about or seen, with each chapter outlining a different practitioner's story, illustrating survival, hope and resilience.

At the time of my doctoral submission I am still in the process of communication with Routledge and am due to submit a draft chapter in January 2017 (see Appendix Y for my proposal and communication with Routledge).

Additional post-doctoral product goals are as follows:

1. To produce a book offering guidelines to practitioners who have experienced client suicide
2. To submit a paper outlining my findings to peer-reviewed journals, such as specialist suicide journals e.g. 'Crisis' or 'Suicide and Life Threatening Behavior'
3. To submit a paper outlining my findings from the five interview transcripts which I was unable to use fully in my research; these were from participants who had had clients make suicide attempts, but did not complete suicide
4. To submit a paper on the professional responsibility model of working with suicidal clients (as highlighted in chapter eight)

9.8 Summary

In this chapter I have outlined the products I have devised, and the opportunities that I have had to disseminate my findings via conferences and seminars. The development of training material for my workshops, and presentation of my research findings at conferences have been the high points of my research journey.

I have an incredible sense of achievement, and feel that I have already made a significant professional contribution in highlighting the issues faced by practitioners when working with suicidal clients. In addition to raising the profile of how the suicide of a client can impact on practitioners, I have been able to create products which prepare and aid practitioners in the complex work which they undertake with their suicidal clients. The evaluations I have received from training workshops, and the verbal feedback from participants have demonstrated the value and importance of this research.

Practitioners have expressed that they feel more confident in their work, and better prepared to see the signs of suicidal intent. Other practitioners have acknowledged their lack of personal self-care, and have made a new commitment to address their own wellbeing. Managers have disclosed how challenged they have felt with regard to the wellbeing of their workforce, and the need to create healthy environments which promote staff support and care.

In the final chapter of this project I will summarise this research study and reflect on my doctoral journey.

Chapter Ten: Summary

In this chapter I will summarise how I carried out my research, and highlight the key findings. I will then outline my experience of working to attain my research objectives, and share a reflective account of the journey.

10.1 A Summary of my Research

Despite government initiatives, suicide rates in England have steadily increased. Those in the field of counselling and mental health have responded to the escalating suicide rates by producing articles, guidelines and procedures on the subject. As a member of the counselling profession I was keen to hear first-hand accounts of those working with suicidal clients, in order to ascertain what would both prepare and support them in their work.

I chose to use a mixed method approach because I thought that it would provide both breadth and depth of knowledge. Polkinghorne (1984), Goss and Mearns (1997) and Haverkamp et al (2005) state that mixed methods research is unique, in that it brings both forms of knowing together at the same time. Haverkamp et al (2005: 124) liken quantitative research to photography in which images are produced 'characterized by precision'. Qualitative research is described as painting a portrait which "can offer a glimpse of what resides beneath''. I also considered that my main products would have a greater chance of a successful outcome though a combined approach.

The first phase of the research involved designing an online survey, in which I incorporated both quantitative and qualitative questions covering a broad range of issues in relation to the impact of suicide on practitioners. The responses to the quantitative questions generated descriptive statistics, and the qualitative responses allowed insight into specific training needs that could be analysed and subsequently used to design a training course based on practitioners' requirements.

I used Braun and Clark's (2006) approach to analyse the qualitative data from the survey. Braun and Clark (2006) suggest that an advantage of this method includes being able to summarise key features from a large body of data, and offer a 'thick description' of the data

set. They go on to highlight that the approach can emphasise similarities and differences, along with generating unanticipated insights.

In the second phase of my research, I undertook individual interviews with sixteen participants using a narrative approach, in order to hear their experiences of working with suicidal clients. Riessman (2008) states that:

> *"…a good narrative analysis prompts the reader to think beyond the surface of a text, and there is a move towards a broader commentary".* (Riessman 2008:13)

My motivation for using a narrative approach was to endeavour to gain rich stories to be included in a publication of practitioners' accounts.

In my quest to gain multiple types of knowledge and to formulate products which would be meaningful to practitioners, I chose to analyse the data from a further perspective. In addition to carrying out a narrative approach on each of the interview transcripts, I also combined this approach with Braun and Clark's (2006) use of thematic analysis in order to compare the data across all of the interview transcripts.

The findings from phase one demonstrated that practitioners found their work with suicidal clients challenging on a number of levels. Following client suicide attempts, a wide array of thoughts and emotions were provoked in practitioners. It is clear that every experience is different- even for one practitioner there can be differing responses to various suicidal clients. The polarity of views was apparent, with some practitioners expressing satisfaction for a job well done in seeing their client come through a time of suicidal ideation, to others commenting on feeling completely out of their depth and unprepared. Adjustments were made by practitioners following their client's suicide attempt, demonstrating an increase in the practitioner's activity in the way of additional work commitments, and contact with the client in between sessions. The consequence of this may have had an impact on their levels of stress and wellbeing.

The findings showed that practitioners whose clients had killed themselves, experienced a greater sense of self questioning, blame and expression of guilt than those whose clients had attempted suicide. These practitioners also reported making adjustments to their work

following client suicide, but there appeared to be greater levels of self-support in the form of taking time off work, rather than working late, cancelling some planned work and having personal therapy where necessary.

Phase two highlighted powerful content from the narrative analysis, showing the strength and impact which client suicide has on practitioners. The themes typified how overwhelmed they felt at the time of their client's death but also how years later practitioners were still marked by the experience. Practitioners stated "You don't forget", "Thinking about it produces a feeling of horror" and "It creates anxiety and apprehension when I encounter similar patients".

The thematic analysis carried out at phase two produced five themes- reaction to the news, personal beliefs and anxieties, relationships, resilience and environment. Within these themes it was identified that whilst practitioners experienced many different thoughts, emotions and behaviours as a result of their client's suicide, there were also commonalities. Each practitioner had survived the devastating loss of their client and been able to reflect and learn from the experience, in order to continue to work with and support other clients.

Analysis from a mixed methods pluralistic perspective suggests that there is not a single answer to the issues highlighted. My curiosity and desire to consider varying perspectives and different practitioners' viewpoints has led me to acknowledge that following client suicide practitioners will be best supported if the issue is recognised as a shared responsibility.

Shared responsibility entails professional bodies, employers, training providers, supervisors and practitioners working together to maintain standards of care, support and training. This will aid and prepare practitioners for working with suicidal clients, and should their client die by suicide practitioners will have a greater degree of support to enable them to negotiate the practical, emotional and professional challenges in the days and months which follow.

As a result of my research I have devised training workshops formulated directly from the research data; these workshops are bespoke and tailored to the needs of the group. The content and manner in which the workshops are delivered, has enabled many participants

to receive a high quality of training to prepare and support them in their work with suicidal clients.

From my research findings I have been surprised that self-care has featured so highly. Yet as I have considered the data further I have been struck not just at a professional level of how practitioners can have such a poor life and work balance but also at a personal level. I have come to acknowledge how I have overridden my own self-care needs. A further surprise was in relation to unhealthy expectations of employers who think only of the business and not the well-being of their staff. Following a number of the interviews I was deeply moved by the reflections of participants of their workplaces. Again I was personally challenged by the practitioners workplace experiences which has caused me to review my own management style and the way I lead my own staff team. This has been a catalyst for me being invited to join steering groups on self-care and staff support.

Limitations of this study were identified as being the volume of data, the high ratio of counsellors/psychotherapists in relation to other professional groups, having to simplify the method of narrative analysis and my own very personal weaknesses which may have limited the study.

I would suggest that further research is necessary to measure and analyse the longer term impact on practitioners at various stages following the suicide of their client. I personally would like to revisit my own participants and consider together what changes they may have experienced in the lapse of time since we met in 2015. I would also propose research to monitor supervision and its benefits on professions who are not required to have clinical supervision as a mandatory requirement.

10.2 A summary of the Journey

From the outset of this research journey my quest was not only to answer my research question but also to challenge myself at a personal and professional level; however, perhaps naively I was not expecting to encounter deep truths about myself.

Having a learning difficulty feels like a curse; it has been the dark cloud hanging over me from my earliest experiences of education. It is like wearing a helmet, which prevents my

creativity leaving my mind and arriving on the page. I spend hours writing and rewriting, trying to form sentences and then paragraphs, only to feel utterly frustrated and critical of myself , with a hatred of this 'curse', and of myself for being so stupid. I look at others and observe the ease with which they write or convey deep and meaningful truths which leaves me feeling inadequate.

In the light of these challenges, embarking on a doctorate would seem at best an act of foolishness and at worst perhaps an act of self-harm. Regardless of being a fool, or having a death wish, I commenced this research in the hope that somehow I would make it through to the end and achieve that elusive doctorate.

As a person who likes to be in control- who needs to plan and does not like surprises- choosing a mixed methods approach was out of character. However, I chose a relatively complex approach to research rather than going for a more straightforward method, because I wanted to try something which was unfamiliar. I wanted to challenge myself and endeavour to let go of my certainties by using social constructionism to enrich my thinking. I was intrigued by the notion of letting go of 'my normal way', and arriving at an end point via bewilderment and confusion, to perhaps a place of new insight.

Willig (2013) suggests that social constructionism is based on the idea that there are plural 'knowledges' rather than singular 'knowledge'. Social constructionism places an emphasis on events and experiences being seen or described in varying ways. These different ways of knowing or understanding can coexist with neither way being wrong.

I began to wonder how this idea of 'knowledges' might influence my research; it may in fact provide me with far more than I anticipated. Perhaps trying to be 'in control' actually contains and limits not just me as an individual, but also my research. The concept of truth having thick or thin meaning, caused me to consider the possibility of hearing multiple narratives or truths.

Using a mixed methods approach has pushed my frailty to its limits; at times I have felt overwhelmed, confused, out of my depth, blank and empty. I have questioned my ability to negotiate the complexities of using several methods, and yet I have had to remain focused and determined to press on despite the difficulties which I have encountered.

The journey has also taken much longer than anticipated. It has required a discipline of which I did not think I was capable. It has also demanded sacrifice of time, and has been hard to sustain whilst working full time in a demanding role.

The experience of reading and hearing the stories of my research participants has been such a privilege. Yet to be faced with their pain, turmoil, angst, despair, struggle, strength, determination, survival and courage has caused me to feel waves of intense emotion and parallel processes.

This research process has also professionally challenged me, in that despite having years of training as a psychotherapist, and believing that I was reasonably accomplished, I have realised that in fact on occasions I have presented myself to clients as detached, jaded and unable to hear the story from another view point. I have now embraced the idea that if I could embody this learning, it may have a powerful impact on my ability to see multiple perspectives- not just in my research, but with my clients, and in other aspects of my life.

I have come to recognise that due to my early experiences of death, rejection and loneliness I have seen myself as broken, inferior, invisible and a failure. I have come to understand that the loneliness I experienced as a child, caused me to become a good observer of people, able to detect pain in others and to really care about their feelings. I had thought that the pain and perceived rejection I felt as a child had made me weak, and yet I have come to know that my sense of failure has in fact become 'the making of me'. I have learned from failure to try again, and not to give up; I have learned how to maintain a spirit of hope and optimism.

I can acknowledge how hard the journey has been, and yet how far I have come. I have achieved so much because the broken, lonely child was stronger than she thought. To observe that she has been strong enough not just to survive, but also to thrive has been transformational. Wicks (2008) refers to the idea of self-respect being true self-awareness, and I believe that this is something I have come to understand.

I recognise that the years of school- based humiliation due to my learning difficulties, has not stopped me becoming a success. This research journey has given me new insight; the truth is that I have not been criticised in a damaging way for decades, and in fact I am the

only one who tells me that I am 'stupid'. This revelation has given me a new sense of substance and potency.

I am a vulnerable human being- in common with the rest of humanity, but my experience of this research journey has been life changing. The feedback that I received for my RAL 7 in January 2013 from Dr David Mair and Prof Paul Barber has been something that I have continued to return to, in order to encourage myself during the difficult times. In addition, my Academic Advisor Stephen Goss, has convinced me that I am not an imposter or fraud, and that I have a contribution to make to the profession.

In consequence, my inner critic has not been silent but has become less powerful. I now have the ability to show compassion to myself when I hear that critical voice. I experienced many traumas in childhood which left their scars. Some of their consequences have meant that I have positioned myself out of the spot light, not putting myself forward in some situations and not allowing myself to acknowledge my successes.

Living like this has meant that I have not been true to myself, or to who I really am. As I have had opportunity to share my research, to demonstrate my products via training workshops, to take centre stage and to speak with authority, I have noticed a freedom in my communication and a liberty to be myself. I feel that I have come 'out of hiding', and when I speak I do not just deliver information about my research findings, but my personality is fully present, which enables me to communicate a difficult subject with sensitivity, enthusiasm and passion.

I am aware of how fixed my viewpoint has been on occasions, and through the research process I have allowed myself to let go of control, certainty and instant appraisal to find new perspectives. The cost of giving up control has caused me to experience bewilderment, confusion and utter uncertainty: yet what I have gained at a personal and professional level has been life-enriching.

I have been able to hear the narratives of all of the participants, and to present their voices through this research study, and in conclusion, I would like to acknowledge their bravery for speaking about very personal experiences. Through them I have learned so much, and their

stories, views and ideas have been used through the products I have developed to train and influence many other professionals working with suicidal clients.

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List of Appendices